Submission for the

Focused Review of How the Change or Suppression Practices Ban Is Working

Victorian Law Reform Commission 2026

LGB ALLIANCE AUSTRALIA

About LGB Alliance Australia

Our Vision

Lesbians, gay men and bisexuals living free from discrimination or disadvantage based on their sexual orientation.

Our Mission

To advance lesbian, gay and bisexual rights

We advance the interests of lesbians, gay men and bisexuals, and stand up for our right to live as same-sex attracted people without discrimination or disadvantage.

We will ensure that the voices of lesbians, gay men and bisexuals are heard in all public and political discussions affecting our lives.

To highlight the dual discrimination faced by lesbians

We amplify the voices of lesbians and highlight the dual discrimination experienced by lesbians as women who are same-sex attracted in a male-dominated society.

To protect children who may grow up to be lesbian, gay, or bisexual

We work to protect children from harmful, unscientific ideologies that may lead them to believe either their personality or their body is in need of changing. Any child growing up to be lesbian, gay or bisexual has the right to be happy and confident about their sexuality and who they are.

To promote free speech on lesbian, gay and bisexual issues

We promote freedom of speech and informed dialogue on issues concerning the rights of lesbians, gay men and bisexuals. We assert that different opinions, even those we may disagree with, should be heard as part of the public debate.

You can find out more about us on our website – www.lgballiance.org.au
You can get in contact with us on email – contact@lgballiance.org.au

Follow us on social media:

www.facebook.com/lgballianceaustralia
www.twitter.com/lgballiance_aus
www.youtube.com/c/lgballianceaustralia

Introduction

Dear Attorney General,

Thank you for the opportunity to provide input into the Victorian Government's review of the Change or Suppression (Conversion) Practices Prohibition Act 2021. We welcome the review as an opportunity to reflect on the impact and direction of the Act. I write on behalf of LGB Alliance Australia, Australia's leading advocacy organisation representing the voice of lesbian, gay and bisexual people.

LGB Alliance Australia's submission focuses on three issues: whether the Act has materially reduced harmful practices, whether its drafting has produced unintended consequences for clinical care, and whether further clarification is needed to support lawful therapeutic practice.

On behalf of LGB Alliance Australia, I thank you for considering our submission. Should you have any questions or you would like further detail, we invite you to contact us. We confirm that our submission complies with the Submission Policy and we consent to it being published without redaction.

[redacted]
President
LGB Alliance Australia

Focused Review of How the Change or Suppression Practices Ban Is Working

1. **Has the Act reduced or stopped change or suppression practices? Describe any impact you think the Act has had on the occurrence or the nature of change or suppression practices. Could the Act's operation and effectiveness be improved? If so, how?**

Gay conversion practices have been thoroughly discredited as having no scientific basis and have fortunately been rare in Australia even as similar practices were more common in other jurisdictions. The limited evidence of conversion therapy in Australia that does exist highlights that conversion efforts tended to be informal, small-scale, and often religious in nature, rather than organised clinical programs. The prevalence of these practices was and is significantly lower than in other countries (e.g. parts of the United States) where such practices were (or remain) legal or loosely regulated and socially acceptable. For example, a national search for survivors of Sexual Orientation & Gender Identity Change Efforts (SOGICE) in Australia in 2024 identified only 87 people who self-declared they might have previously experienced a change or suppression practice[1]. These self-declarations were not validated nor timebound – for example, some survivors may have experienced these practices in the 1950s. This mirrors a study by La Trobe University which identified less than 50 people nationally who had undergone some form of change or suppression practice[2].

The conversion practices that the Act sought to ban have been in natural decline as gay conversion practices have been discredited as scientifically baseless and futile. There is no evidence that the *Change or Suppression (Conversion) Practices Prohibition Act 2021* has altered an already declining trend. When the Act was introduced in 2021 these practices were already incredibly rare in Australia.

[1] SOGICE Survivor Statement

[2] https://www.latrobe.edu.au/news/articles/2018/release/report-on-lgbt-conversion-therapy-harms

2. To what extent do you think the community is aware of and understands:
   a) the Act and how it works
   b) what change or suppression practices are
   c) the harm caused by change or suppression practices.

The LGB community understands intuitively what **sexual orientation** change and suppression practices are (b) as well as the harm caused by these same practices (c). Our consultation has identified that there is a generally good but basic understanding of these practices in the mainstream lay community whereby it would be identifiable to community members were they to encounter it. We have not directly consulted on whether our members, LGB people or the mainstream are specifically aware of the Act or how it works (a).

Generally speaking, there is strong familiarity in what constitutes **sexual orientation** change and suppression in professional sectors such as health care, particularly amongst providers targeting LGB patients, advocacy services and associated legal services on (a), (b), and (c).

On **gender identity** change and suppression practices, the reality is very different. Our consultation has identified that many psychologists feel uncertain about the Act when working with young people who are confused or distressed about their gender, because the legislation is broad in its definitions (Section 5 (1)) and the boundary between exploration and suppression is not always clearly defined in practice. Clinicians worry that routine evidence-based therapeutic activities such as encouraging a young person to slow down, explore underlying factors, consider multiple possibilities, or reflect on whether their feelings might relate to trauma, autism, internalised homophobia, or social pressures could be misinterpreted as an attempt to "suppress" a gender identity.

Our concern is not that psychologists want to change or supress a young person's identity, but that the law's wording may expose them to complaints or investigation if a patient later feels that exploratory therapy delayed or questioned their self-identified gender. The emerging international evidence in reviews of youth gender medicine and gender affirming care since the introduction of the Act have highlighted the importance of robust psychological care given to gender-questioning adolescents given the over representation of mental health concerns amongst this cohort, many of whom would simply grow up to be happy and healthy gay or lesbian adults if allowed to explore their feelings and develop naturally. There are many young adults de-transitioning today who are dealing with lifelong medical consequences because of premature medicalisation. More exploratory psychological therapy may have saved these young victims a lifetime of regret.

This perceived risk to clinicians can create a chilling effect where clinicians feel pressured to affirm immediately rather than engage in the open-ended, developmentally appropriate exploration that is standard in other areas of adolescent mental health. Specifically, we draw the review's attention to a recent paper published by Psychiatrist Dr

Roberto D'Angelo that explains how the wrong lessons have been learned from historical gay conversion practices that influence treatments for gender-questioning children and adolescents today. A copy of the paper is attached at Annexure A.

3. Could the Act's operation and effectiveness be improved? If so, how?

We do not consider the lack of prosecutions under the Act to reflect it operating poorly. As stated above, sexual orientation change or suppression practices have for practical purposes disappeared without legislative intervention. Similar trends have occurred in other jurisdictions without legislation specifically preventing "gay conversion" practices.

The absence of prosecutions has also produced an absence of case law. This means that there is little practical guidance on where the boundary lies between prohibited suppression and legitimate therapeutic exploration. Some clinicians fear that even well-intentioned, evidence-based caution such as recommending more time before social transition, or exploring whether distress may relate to trauma, autism, or internalised homophobia could be misinterpreted as an attempt to dissuade or "convert" a young person from a gender identity. This uncertainty can discourage psychologists from accepting gender-questioning adolescents as clients or from providing the full scope of exploratory care that is standard in other areas of youth mental health. This is a perverse outcome and harmful for patients, many of whom are or will grow up to be lesbian, gay or bisexual.

LGB Alliance Australia recommends that gender identity be removed from the scope of the Act. Failing that, a clearer distinction between exploratory therapy and suppressive intent could be achieved by explicitly recognising in the Act and accompanying guidance that open-ended, developmentally informed exploration is a legitimate and necessary component of psychological care for young people.

Science informs us that sexual orientation has significant biological determinants while gender identity can be more susceptible to social influences. Attempting to 'convert' someone in relation to their sexual orientation, as demonstrated by evidence of the ineffectiveness and adverse psychological consequences of past homosexual conversion practices, is distinctly different to the action of counselling or providing psychotherapy for a child or adolescent experiencing symptoms of gender dysphoria (to which social factors are known to be contributory) with the intent to assist symptom resolution as commonly occurs following puberty.

Clarification should articulate that evidence-based exploratory therapy involves helping a young person understand their feelings, consider multiple possibilities, challenge beliefs and examine co-occurring factors without steering them toward any particular identity outcome. Suppressive intent, by contrast, could be defined as conduct that employs discredited pseudo-psychological or religious practices for the purpose of directing a person away from a particular gender identity or pressuring them toward another. Embedding this distinction in explanatory memoranda, regulatory guidance, or professional standards would give clinicians confidence that reflective, evidence-based

assessment is not prohibited, while still ensuring that genuinely harmful practices remain unlawful.

4. **How clear is the Act's definition of what is and what is not a change or suppression practice? If further clarity is needed, what forms of clarification would be most helpful?**

The definitions in Section 5 of the Act are broad and therefore unclear. The broad nature of the definitions employed in the Act has given rise to the problems outlined in our responses to Questions 2 and 3 above.

5. **How clear is the exclusion for health service providers? If further clarity is needed, how could this best be achieved?**

Exclusions for health service providers are unclear. Please see responses to Questions 2 and 3 above which explain the concerns we have identified in our consultations with clinicians. If gender identity remains in the scope of the Act after the review, clear safe-harbour provisions should be provided for medical practitioners providing psychological treatments to gender-confused children and adolescents. Clearer statutory examples or regulator guidance illustrating permissible exploratory practice would assist.

Since the Act was legislated in 2021, the weight of evidence has shifted away from unquestioning 'affirming' models of care for gender-questioning children and adolescents to a more cautious approach that places greater emphasis on psychological therapies, questioning and exploration. This has been reflected in evidence reviews, legal rulings and revised practice guidelines internationally. The Act could be causing direct harm to gender-questioning children and adolescents in Victoria. The Act should operate neutrally between lawful therapeutic approaches because its purpose is to prevent harm, not to privilege any particular model of care. In practice, however, it appears to favour one approach. Its drafting and operation expose exploratory and cautious therapeutic work to greater regulatory risk, while affirming approaches are less likely to attract scrutiny. This creates uncertainty for clinicians and may distort professional judgment by signalling that one pathway is safer from complaint than another. The law should instead set clear, even-handed boundaries that protect patients while allowing clinicians to exercise their professional judgment in good faith. Clarifying the Act to ensure neutrality would better support patient welfare and consistent clinical practice.

6. **Is greater clarity needed about how people of faith can hold and express their beliefs to support clear understanding and compliance with the Act? What forms of clarification would be most helpful?**

LGB Alliance Australia does not hold a position on this question.

7. **How effective are VEOHRC's awareness and education materials on change or suppression practices? What improvements, if any, could help strengthen community understanding and compliance?**

Lack of awareness or a deficiency in training or education materials have not caused the lack of prosecutions under the Act, rather the absence of offences. Notwithstanding, more plain-English descriptions such as "gay conversion therapy" may resonate better with the general community rather than current bureaucratic "change and suppression practices" language that has been adopted.

We do not consider the increase in notifications to VEOHRC set out in section 3.4 of the consultation paper to be statistically meaningful but rather evidence that conversion practice prevalence is low.

LGB Alliance Australia is more concerned with the Act's unintended consequences that restrict access to high-quality psychological care for gender-questioning children and adolescents. It is very important to acknowledge the accumulation of research and data since the Act's inception that has shifted the weight of evidence away from medicalised pathways for gender-questioning children and adolescents in favour of a more cautious approach that prioritises robust psychological assessment. This is notably absent from the consultation paper. It is a perverse outcome of the Act that the clinicians best placed to support these vulnerable young people are dissuaded by the ambiguity in the Act.

8. **Are there any barriers to:**
   a) **reporting change or suppression practices to VEOHRC**
   b) **VEOHRC facilitating outcomes of reports**
   c) **VEOHRC conducting investigations.**

   If so, please describe what those barriers are.

No. LGB Alliance Australia does not consider there are barriers to reporting or investigations that is the reason behind the lack of investigations or prosecutions under the Act.

9. **Are there changes that could help support VEOHRC to carry out its functions or improve the effectiveness of the civil response scheme? If so, please describe any changes.**

There is no evidence to suggest that the civil response scheme is not functioning as designed and the low level of activity reflects the absence of identifiable conversion practices, not a flaw in the scheme itself. We consider that there may be no structural or procedural changes that would materially increase its utilisation, because the underlying conduct the scheme is designed to address is extremely rare. The scheme remains available and fit-for-purpose, but its low caseload reflects the reality that there are few, if any, cases to bring forward.

LGB Alliance Australia does not support the introduction of a positive duty to report and prevent conversion practices. Not only is this unnecessary, but it would also create

greater confusion for psychologists and other mental health service providers. It also carries negative connotations for LGB people in the general community with the potential to create additional stigma for LGB people.

10. Are there barriers to reporting, investigating and prosecuting criminal change or suppression offences? If so, what are they?

LGB Alliance Australia does not support legislative change to introduce an offence that does not require proof of injury. This is unnecessary and would exacerbate the current risks to psychologists and mental health service providers working with gender-questioning young people. This would be a retrograde step and potentially cause more health service providers to decline to take on young LGB and/or gender-questioning patients.

Barriers to reporting, investigating and prosecuting criminal change or suppression offences arise mainly from the nature of the conduct the Act targets, rather than from flaws in the criminal provisions themselves. Our consultation with members and the LGB community does not indicate that the reasons set out in section 4.4 of the consultation paper contribute to the lack of prosecutions in Victoria (or other jurisdictions in Australia).

The Victorian Crime Statistics Agency recorded-offence data illustrates the very low level of criminal conduct captured by the Act. The latest available data show no recorded offences in the year ending September 2023, one recorded offence in the year ending September 2024, and none recorded in the year ending September 2025[3]. In this context, discussion of barriers to reporting or enforcement should be approached with caution. The available data does not indicate an unmet enforcement need or support expansion of penalties, offences or regulatory mechanisms. At the same time, concerns raised by clinicians about uncertainty in the Act's scope suggest the more pressing issue is not under-enforcement, but the unintended consequences of the current drafting for lawful therapeutic practice.

Notwithstanding the low prevalence of suppression practices in contemporary Victoria, a significant portion of people who have experienced a change or suppression practice will choose not to pursue a criminal prosecution because they have moved on with their lives and doing so can come at a significant personal cost. Reporting often requires revisiting painful experiences, disclosing intimate details of family, faith, or community life, and potentially confronting people with whom they still have ongoing and improved relationships.

The life experience for LGB people can be very different from the mainstream community. Many LGB people have faced substantial setbacks and prejudice in their lives that they have overcome, often unrelated to conversion or suppression practices. Having rebuilt their lives, established stability, or moved away from the environments in which the harm

[3] Victorian Crime Statistics Agency - Offences Recorded – Tabular Visualisation, Table T5, accessed 12 March 2026

occurred, engaging with the criminal justice system would pull them back into a chapter they have worked hard to leave behind. For many, the desire for closure and privacy outweighs any perceived benefits of prosecution. Notably, more than half of the survivors of change and suppression practices identified in the La Trobe study referenced in Question 1 were disqualified from the study for reasons including high risks of mental distress and trauma from revisiting experiences of conversion therapy.

11. Are there other aspects of the criminal offences in the Act that limit their effective operation? If so, what changes or supports could improve their operation?

No. Please see response above to Questions 9 and 10.

12. Do existing avenues for redress adequately meet the needs of victim- survivors of change or suppression practices? Are there gaps, harms or barriers that require an additional or separate redress mechanism?

Broadly speaking, yes. LGB Alliance Australia does not object to a redress scheme as a matter of principle however questions the need for, or merit of, a redress scheme relative to other competing priorities. The low prevalence of change and suppression practices, overlayed with the smaller number of victim-survivors who would wish to pursue potential claims means the administrative cost of establishing a dedicated scheme would be difficult to justify and could risk attracting stigma to LGB people. We would advocate for greater funding for LGB mental health services over and above the creation of a bespoke redress scheme. The existing Victims of Crime Financial Assistance Scheme should be utilised as well.

13. Should a civil cause of action be introduced under the Act? What distinct purpose would it serve compared to existing pathways?

LGB Alliance does not support the introduction of a civil cause of action to be introduced under the Act. Introducing a civil cause of action would risk creating an adversarial dispute-resolution system that is open to abuse and vexatious litigation. There is substantial precedent for transgender rights activists abusing and weaponising complaints processes. There is a risk that a civil action scheme could exacerbate the risks faced by medical providers already outlined above and would threaten the ability of LGB and gender questioning young people's access to essential services.

INT J PSYCHOANAL
https://doi.org/10.1080/00207578.2025.2591921

Routledge
Taylor & Francis Group

OPEN ACCESS

Trans is not the new gay: How psychoanalytic elitism and the rejection of science are creating a repetition of the past

Roberto D'Angelo [a,b]

[a]Training and Supervising Analyst, Institute of Contemporary Psychoanalysis, Los Angeles, CA, USA; [b]Society for Evidence-based Gender Medicine, Twin Fall, ID, USA

ABSTRACT

Psychoanalysis has a troubled history with regard to sexual minorities. Throughout much of the twentieth century, prominent analysts endorsed a highly pathologising and coercive approach to homosexuality, which was essentially a form of conversion therapy. This departure from accepted analytic technique persisted for decades due to psychoanalytic elitism and the rejection of mounting empirical science contradicting the psychoanalytic position. Today, a pressing concern for psychoanalysis is to avoid repeating this history when theorising about and working with transgender people. Psychodynamic explorations of trans identity formation are being framed as new iterations of conversion therapy, wrongly implying coercion and falsely conflating psychodynamics with pathology. Furthermore, the author cautions that unquestioning gender affirmation shares an important conceptual similarity with gay conversion therapy, in that it can collude with a wish to eliminate a shame-filled or hated part of the self. In our haste to avoid repeating the past, psychoanalysis is deploying the very same tactics that insulated its stance on homosexuality from revision and course correction, but now with regard to trans. The author argues that if we are to avoid causing further harm to our patients and our profession, we ignore the science at our own peril.

KEYWORDS

Transgender; homosexuality; conversion therapy

> "We may believe that we are currently on the moral high road; but it is well to remember that psychoanalysts of past generations who were well trained, intelligent, diligent and empathic believed the same". (Friedman and Downey 2016, 340)

Introduction

Psychoanalysis has a troubled history with regard to homosexuality. Schwartz (2022) asks the most important question in relation to this issue: how can we prevent a future repetition of the "moral and intellectual debacle" of the psychoanalytic approach to homosexuality?

CONTACT Roberto D'Angelo roberto@robertodangelo.com

This article has been corrected with minor changes. These changes do not impact the academic content of the article.

> perhaps the most obvious [way]: teach our history as part of training, including its shameful moments. The telling of history is part of the present – we must know it correctly to go forward cleanly. To know it in its ugliness may immunize us against its easy repetition. (Schwartz 2022, 16)

And, perhaps most importantly: "where relevant data and scientific findings exist, grapple with them. Psychoanalytic data is special, unique; but its conflicts with controlled, scientific data must always be examined" (Schwartz 2022, 16). This history is often invoked in relation to current discussions about trans issues in both clinical and lay communities. It serves as a warning that any perspective diverging from the position that trans identities are universally an expectable manifestation of human gender diversity risks repeating the injustices and harms that were inflicted on gay people in the twentieth century. Psychoanalysis, and in fact most of mainstream medicine, is fighting for the full depathologisation of trans and for widespread access to gender-affirming interventions. Clinicians who seek to explore the psychodynamic formation of trans identities are accused of promoting conversion therapy – a trans version of the coercive treatment administered to homosexuals. Similarly, scientific data questioning the safety and effectiveness of medical and surgical gender reassignment is framed as misinformation deriving from an inherent, pathologising bias against gender diversity and trans people. Psychoanalysis is taking the moral high road and claims to be on the right side of history this time, demonstrating our collective desire to protect sexual minorities from another round of harm.

Our collective guilt about the past, coupled with our anxiety to avoid repeating it, is in fact fuelling a repetition of the very thing we are trying to avoid. While the history of the "intellectual and moral debacle" of our attitude towards homosexuality is now widely known, psychoanalysis has yet to fully confront the full ugliness of that history. Perhaps the single most significant reason this harmful chapter of our history continued for many decades was psychoanalytic arrogance: elitism regarding the superiority of psychoanalytic understanding of human experience, coupled with a relentless rejection of empirical science. To truly immunise ourselves against its repetition, we must confront these uglier aspects of the psychoanalytic enterprise and, by extension, ourselves. Otherwise, we may fail to see that these very same defensive manoeuvres are operating in our profession's current engagement with gender, gender dysphoria and transgender, once again exposing our patients to potential harm.

This paper will explore the pathologising approach to homosexuality that dominated psychoanalytic publications during the twentieth century, what ultimately led psychoanalysis to revise its position, and why it took so long. Psychoanalytic authorities rejected emerging scientific evidence that directly contradicted mainstream psychoanalytic thinking about homosexuality, defending their pathologising formulations and their coercive treatment approach for decades – even after homosexuality was officially removed from the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM). Founded by Charles Socarides, the National Association for Research and Therapy of Homosexuality (NARTH) operated from 1992 to 2014 and was arguably the last remaining bastion of psychoanalytic conversion therapy for homosexuals, becoming increasingly isolated (Drescher 2023). Much harm was done to gay people as well as to our profession, as a result of psychoanalysis' refusal to engage with empirical science. This refusal was grounded in the elitist belief that psychoanalysts had privileged access to human experience.

Through exploring coercive psychoanalytic approaches to homosexuality, it becomes apparent that contemporary psychoanalytic approaches to gender dysphoria bear no resemblance to problematic conversion therapies for homosexuality. Mapping the phenomenology of internalised homophobia and gender dysphoria further distinguishes between the psychotherapeutic approaches to each. Many patients experiencing distress about same-sex attraction or gender dysphoria can be understood as being internally divided. They are both struggling with and may be trying to work through an ambivalently held, feared or hated part of the self. Viewed through this lens, a fundamental difference between these two problems emerges. Most psychological therapies work towards integration, helping patients to accept feared, hated or "not-me" parts of the self, and this is indeed the approach taken with patients who struggle with homosexual desire. However, for patients with gender dysphoria, unquestioning affirmation risks rigidifying this internal division and colluding with attempts to distance from or eliminate a part of the self.

Numerous factors contributed to the decades-long persistence of pathologising approaches to homosexuality. These factors combined to insulate idiosyncratic psychoanalytic theories and their proponents from any challenge or revision. Firstly, people who disagreed, or theories that offered a different perspective, were dismissed as not being psychoanalytic. Secondly, empirical science was considered irrelevant to psychoanalysis because it failed to take the unconscious into account and was therefore ignored. Today, we are witnessing a repetition of these phenomena in relation to trans issues. Those who question the prevailing, permissible understanding of trans are devalued as unanalytic. Scientific data that questions the wholesale acceptance of gender medicine is either ignored or misrepresented as misinformation. Once again, psychoanalysts are fighting to defend their positions despite what the science says.

Psychoanalysis and homosexuality

In contrast to Freud's cautious views on the issue, the approach to homosexuality outlined in psychoanalytic publications from the mid-to-late twentieth century was unequivocally pathologising. This aspect of the history of our field has been extensively documented (Chiang 2008; Drescher 2008, 2015; Friedman and Downey 1998, 2016; Isay 1985; Isay and Friedman 1986; Newbigin 2013; Schwartz 2022). The pathological perspective was accepted by the majority of American psychoanalysts (Bayer 1981). It was based on the views of prominent psychoanalysts of the time, including Edmund Bergler and Charles Socarides, who argued that homosexuality was always the result of psychopathology. The most influential of these was Sandor Rado (Friedman and Downey 1998). He believed that homosexuality could only be understood as a "reparative adjustment", a consequence of fear and guilt acquired during childhood, which inhibited heterosexual desire (Rado 1940, 1949). As well as being viewed as a fear of heterosexuality, it was also generally accepted that homosexuality involved a failure to identify with the father, thereby leading to abnormal psychosexual development (Friedman and Downey 2016).

One does not have to look too deeply into the psychoanalytic literature of the time to note the obvious contempt and moral judgement that underpinned these pathological formulations. In the opening chapter of his book *Homosexuality: Disease or Way of Life?*, one of the most prominent clinicians arguing for the pathological nature of

homosexuality, Edmund Bergler, describes homosexuals as "essentially disagreeable people … the shell is a mixture of superciliousness, fake aggression and whimpering … the only language their unconscious understands is brute force" (1957, 28–29). He claimed that all homosexuals displayed certain pathological unconscious dynamics. These included: psychic masochism and injustice collecting, a mortal fear of women, constant dissatisfaction and hence constantly being on the prowl, an unfounded megalomaniacal conviction of the homosexual's superiority, inner depression and exorbitant malice, inner guilt arising from the perversion, irrational jealousy, and unreliability as a manifestation of psychopathic trends. Socarides (1968) noted that half of homosexuals have "concomitant schizophrenia, paranoia, are latent pseudoneurotic schizophrenics or are in the throes of a manic depressive reaction". The remainder are neurotics, or suffer from "character disorders, psychopathic personality or some variety of addiction".

Early studies of the use of the Rorschach to detect homosexuality powerfully illustrate the intellectual bias in relation to homosexuality. In the 1940s, the Rorschach was used to distinguish a "genuine, chronic homosexual" from someone feigning homosexuality to obtain discharge from the army. It was also used to help psychiatrists identify the homosexual who is "hiding behind a conversion symptom". Bergmann (1945) concluded that while not infallible, the Rorschach may be "of practical value to army psychiatrists who may be confronted either with simulators or soldiers accused of homosexuality which they deny". Wheeler (1949) studied the Rorschachs of 100 male patients at the Los Angeles Veterans Administration Mental Hygiene Clinic, developing what would subsequently become known as the "Wheeler signs" of homosexuality. Patients were identified as homosexual by their therapists based on *any* of the following: the patient's own reports of homosexual experience, the patient's report that he had masturbated at some time in his life, the therapist's opinion that the patient had a somewhat effeminate appearance or manner, or an indication that the patient felt hostile towards the mother. The 20 signs he identified, which were associated with these therapist-reported findings, included human or animal oral detail, human or animal anal detail, feminine clothing, dehumanised or animal-like figures, humans or animals described as "back to back", and a human female with a derogatory specification. Based on these findings, Wheeler concluded:

> If it is possible to accept the rationale for each item in terms of the aforementioned results, a combined picture of the male "homosexual" would be: A somewhat paranoid individual with derogatory attitudes toward people, especially women, which is accompanied by a feminine identification. There are indications of anal interests and interest in physical relationships between like beings. There is apparently some preoccupation with sex in general and some autoerotic concern. (Wheeler 1949, 123)

Psychoanalysis had a powerful influence on mainstream psychiatry, with at least one-third of American psychiatrists in the 1950s being psychodynamic in their perspective. Unsurprisingly, then, the early versions of the mainstream diagnostic manual, the DSM, were shaped by psychoanalytic thinking. The DSM-I listed homosexuality as a sociopathic personality disorder (Friedman and Downey 1998). The link to psychoanalysis is clear: identification with the father was considered essential for superego development. Without this paternal identification, homosexuals were deemed to have a defective conscience. The revised DSM-II listed homosexuality alongside other sexual deviations. This edition continued to be used by all psychiatrists until 1980 (Friedman and Downey 2016). However, in

1973, The American Psychiatric Association's Board of Trustees voted to remove homosexuality from the DSM-II's list of mental disorders, replacing it with "sexual orientation disturbance" for individuals distressed by their sexual orientation. Homosexuality was completely removed from the DSM-III, which was published in 1980 (Bayer 1981).

This radical change in the conceptualisation of homosexuality was largely a consequence of emerging empirical science that challenged the prevailing pathological view of homosexuality. Alfred Kinsey and his colleagues had published their groundbreaking *Sexual Behaviour in the Human Male* 32 years earlier (Kinsey, Pomeroy, and Martin 1948). Kinsey's research revealed that homosexuality was far more prevalent than was generally acknowledged. However, these findings had no impact on psychoanalytic theorising and practice; in fact, they were met by hostility in the US, particularly from psychoanalysts (Chiang 2008; Lewes 1988). Subsequent research that further challenged the notion that homosexuality was a mental illness also had little impact.

One of the most important pieces of research was that of Evelyn Hooker, who debunked the earlier work of Wheeler and others. She found that blind expert Rorschach raters were unable to distinguish between the Rorschach results of non-patient homosexual and non-patient heterosexual men (Hooker 1957, 1958). In the 1980s, Richard Friedmann replicated this finding, showing that homosexual men were comparable to heterosexual men in terms of their psychological profiles (Friedman and Downey 2016). A detailed review of psychological testing concluded that no tests could differentiate homosexual and heterosexual individuals and that there was no evidence of greater pathology in homosexual samples (Riess 1980).

The kind of analytic authority that dominated the field for much of the twentieth century meant that ideas which challenged this hegemony were rejected. The refusal to consider new thinking about homosexuality is perhaps one of the most striking examples of this phenomenon. Despite the mounting evidence, psychoanalysts remained sceptical and hostile towards objective scientific data, dismissing it because it failed to take unconscious and dynamic factors into account (Friedman and Downey 2016). Empirical findings were rejected on the basis that statistical data had no relevance to how analysts understood homosexuality in the consulting room (Chiang 2008). Psychoanalysts and dynamically-oriented clinicians led the opposition to the American Psychiatric Association's deletion of homosexuality from the DSM-III (Isay 1985). Therefore, the mainstream psychoanalytic view of homosexuality remained unchanged for decades, even after it was removed from the DSM, despite a growing body of empirical data contradicting this position. Psychoanalysts were among the last to abandon their position (Chiang 2008). Psychoanalysis was dealt a crushing blow to its elitist claims to superior knowledge: when it came to homosexuality, we were wrong. Ultimately, it was science that forced psychiatry and psychoanalysis to change course and stop causing harm.

Conversion therapy

Treatments intended to change sexual orientation from homosexual to heterosexual are collectively termed conversion therapies or sexual orientation change efforts (SOCE) (American Psychological Association 2009). These include medical, behavioural, psychoanalytic, religious and spiritual techniques, which were all used at different times during the twentieth century to cure what was generally considered a mental illness or

sexual perversion. Early behavioural treatments used aversive techniques, such as electric shock or nausea-inducing drugs, while later attempts employed fantasy modification, in an attempt to extinguish homosexual behaviours and desire. Other methods included gender role coaching and abstinence training. Masters and Johnson claimed a high success rate after two weeks of treatment; however, they did not detail their method. All studies reporting successful conversions have poor designs and follow-up. Religious conversion programmes involved therapy by clergy, prayer, unspecified group processes, coercion to relinquish same-sex attraction, exorcism and, in some cases, sexual boundary violations (Beckstead 2012; Davison and Walden 2024; Haldeman 1991; Przeworski, Peterson, and Piedra 2021).

Medical and surgical treatments included the transplantation of testicular tissue from heterosexual males, hypothalamotomy, testosterone or estrogen therapy, and electroconvulsive therapy (ECT) (Silverstein 1991). Oestrogen therapy in males usually resulted in a complete suppression of sexual desire (chemical castration), while surgical castration was also performed in some centres in the USA and Europe. Many centres provided multiple treatment modalities, so that if psychotherapy failed, the treatment could progress to psychotropic medication, insulin shock therapy, ECT, and finally lobotomy (Weston 2016). Thankfully, the treatment of sexual orientation with irreversible medical and surgical procedures, or aversive therapies, appears to be a thing of the past. The rest of this paper will focus specifically on the use of psychotherapy and psychoanalysis as conversion therapies.

During the mid twentieth century, psychoanalysts believed that the defences repressing heterosexual desire could be undone, so the treatment goal was to achieve a heterosexual orientation. At the time, psychoanalysis was believed to have the power to totally reorganise the personality (Friedman and Downey 1998) – an assertion which now seems exceedingly ambitious, if not grandiose. This was coupled with the pervasive certainty with which psychoanalysis felt it had the authority to pronounce the truth about human nature and the mind. This applied not only to theoretical explanations, but also in the consulting room, where analysts believed they were in a privileged position to know what was going on in the patients' minds. Interpretations contained truths that patients might accept or resist (Mitchell 1998). A prominent theme in mid-twentieth-century psychoanalytic writing about homosexuality was that analysts should use their authority to actively discourage homosexual behaviour and encourage heterosexual behaviour (Mitchell 1981).

Mitchell (1981) was the first analyst to draw attention to what he termed the "directive-suggestive" approach to homosexuality. He noted that this approach violated fundamental analytic principles, which require the analyst to approach all material with openness, neutrality and curiosity.[1] Prominent analysts who advocated this approach included Irving Bieber, Lionel Ovesey and Charles Socarides. Ovesey (1969) describes the features of technique that are specific to the treatment of homosexuals. The overarching approach is that the therapist should encourage heterosexuality and discourage homosexuality. The therapist should apply pressure to date women or to experiment with kissing and petting and

[1] Mitchell (1981) argues that while this approach dominated analytic writing about homosexuality, it was not reflective of the practice of the majority of psychoanalysts who, when working with homosexual patients, continued to adhere to fundamental analytic principles.

each attempt should be praised. If the patient procrastinates unduly about dating women, he should be threatened with termination. Homosexuality should be interpreted as a symptom and a defence each and every time it occurs. If the analyst is silent in response to homosexual behaviour, this may be taken as tacit approval. He recommended explicit education for patients about the pathological nature of homosexuality, with interpretations focusing on its defensive and pathological functions. Importantly, "with shaky patients … the therapist should commit the magic omnipotence with which he is unconsciously endowed in the transference, and guarantee ultimate success, contingent, of course, on further efforts by the patient" (1969, 123). Like Ovesey, Socarides emphasised that patients should be educated that the lack of interest in women is due to a fear of women rather than a lack of desire. He recommended the outright prohibition of homosexual behaviour and the dismantling of any rationalisations that attempt to frame homosexuality as normal. He also recommended utilising identification with the analyst to encourage heterosexual behaviour (Mitchell 1981).

All of these treatment approaches involved coercion and the analyst's overt influence to change the patient's behaviour. This was not simply a modification, but a significant a departure, from accepted analytic technique. Coercion and influence arguably form the basis of all conversion therapies, including the misuse of psychanalysis to change sexual orientation. Alongside this departure from analytic technique, the mid-twentieth-century analytic stance positioned the analyst as an expert who, through repeated interpretations, could reveal the truth about the patient's deepest struggles and psychopathology. Patient objections to these interpretations were considered to be a form of resistance. This stance was increasingly problematised in the latter part of the twentieth century, with critics highlighting the sadomasochistic quality and persecutory effect of this kind of "all-knowing", authoritarian approach to psychotherapy (Hoffman 1992; Meares 1977; Mitchell 1978, 1998). Such an approach risks enforcing and exploiting compliance,[2] shutting down thinking and foreclosing curiosity, and inducing shame. Contemporary analytic theory now views the kind of analytic authoritarianism on which this approach hinges as problematic and antithetical to an evolving analytic process. Meaning is now considered to be mutually constructed, with the analyst's "asymmetrical" participation being to safeguard the process of unfolding curiosity and enquiry, rather than delivering authoritative interpretations (Mitchell 1998).

Psychoanalysis and trans

One of the most pressing concerns among psychoanalysts regarding the growing visibility of transgender people in our communities and consulting rooms is ensuring that we do not repeat how medicine and psychoanalysis treated homosexual men and women in the twentieth century. Consequently, psychotherapeutic approaches that attempt to explore the psychodynamics and unconscious organisation of gender dysphoria and trans identities are condemned as a contemporary version of the kind of approach recommended by Socarides, Ovesey and Bieber. Vocal analytic clinicians warn that such approaches are not only transphobic, but also covert forms of conversion

[2]See Mitchell (1981) for a detailed description of the exploitation of transference compliance to promote behavioural change, ultimately a transference–countertransference enactment, by proponents of the "directive-suggestive" approach.

therapy, that seek to eliminate transness and gender diversity altogether (American Psychoanalytic Association Committee on Gender and Sexuality 2023; Ashley 2022; Drescher 2023; Saketopoulou 2022, 2025; Saketopoulou and Pellegrini 2023).

In the preceding section, I outlined how the psychoanalytic approach to homosexuality, as promoted by analytic authorities at the time, violated fundamental principles of psychotherapeutic and psychoanalytic technique, drawing on Mitchell's (1981) observations. Similarly, any psychotherapeutic intervention that seeks to change gender identity through coercion or undue influence exists outside the bounds of accepted psychotherapeutic practice. I have not been able to find any contemporary psychoanalytic writing that advocates this kind of coercive approach to working with gender distressed or trans people. More problematic, however, is the assumption that exploring the psychodynamic shaping of transgender experience necessarily means rooting out pathology with the express purpose of making gender non-conforming people conform to conventional gender norms. Mitchell (1978) addressed this issue in relation to homosexuality almost 50 years ago. He highlighted two opposing views of homosexuality: (1) that it was a pathological state caused by problematic childhood experiences, and (2) that it was not pathological, but simply a spontaneous expression of sexual diversity.

Mitchell's paper was prescient, as these opposing and seemingly irreconcilable points of view also exist today in relation to trans people. He argues that this binary is based on the mistaken assumption that psychodynamic causation implies pathology – a historical artefact of the evolution of psychodynamic thinking. Freud worked backwards from the symptoms his patients were burdened by to uncover their unconscious psychogenic roots. Psychodynamic explanations were causal mechanisms that explained the development of psychopathology (Mitchell 1978). However, contemporary thinking has changed substantially due to subsequent developments in psychoanalytic theory.

> The application of psychodynamic understanding has provided a complex interpretive system of meanings for viewing the textural fabric of human experience. "The interplay of forces in the mind", to use Freud's phrase, is now viewed as the underlying context for all mental phenomena, including thinking itself. Psychodynamic origins and processes from all developmental levels are understood to be inextricably woven into healthy as well as pathological functioning. (Mitchell 1978, 256)

Those of us who work with transgender patients continue to learn as we accompany them on their developmental journeys, which necessarily traverse a wide terrain through and beyond gender. Most clinicians would agree that trans is not a monolithic entity and that the history, formation, shape and texture of trans identity are unique to each individual patient. Over time, some identifiable patterns may emerge in this diverse group; however, no universal formulation can encompass everyone in this clinical population. Rather than seeking pathology, psychodynamic understanding can be enriching for our patients, adding texture, nuance and complexity to individual trans experience, in the same way that it does for heterosexual, gay, lesbian and bisexual patients. Some are calling for a radical revision of psychoanalytic thinking, implying that our current understanding of the mind is necessarily pathologising to trans people. However, we seem to have forgotten Mitchell's important reminder that equating psychodynamics with pathology reflects a profound misunderstanding of psychoanalytic theory.

Every experience, thought and behaviour is inextricably underpinned by multiple psychodynamic processes and forces. This is the principle of overdetermination. In addition to psychodynamic conflicts, it is crucial to note that human experience is also shaped by adaptive aspects and strivings for psychological growth, including the satisfaction of needs, and the formation of meaningful interpersonal connections (Mitchell 1978). Furthermore, behaviours originating from conflict do not have to be forever grounded in psychic difficulty:

> What isn't allowed for is the possibility that the homosexual [transgender[3]] orientation may be determined by early psychodynamic factors, including conflict and anxiety, but that as the later relationships of the person develop, the original conflicts and anxieties may no longer be the salient motives for the behaviour, which has now become secondarily autonomous. (Mitchell 1978, 258)

Not all established psychoanalytic thinking is pathologising or anachronistic. For example, I have become increasingly interested in understanding gender dysphoria through an interpersonal-relational, dissociative model of the mind. I have found it helpful to view the disgust/shame/horror evoked by the natal body/gender as heralding the imminent emergence into consciousness of a "not-me" state (Stern 2010; Sullivan 1953). Through this lens, it is not that gender is the problem: gender has been recruited to deal with intolerable states that have formed an amalgam with the intolerable gender, creating a powerful way of maintaining the unbearable in an unformulated state. A dissociative process has become structuralised through the unique assembly of "me" and "not-me" that constitute individual gender experience. "Not-me" does not necessarily signify pathology: contemporary dissociative models of mind consider these processes to be universal to the human experience. The aim of treatment is to bridge the internal divisions between self-states and to help transform "not-me" into "feels like me" (Stern 2022). It is important to note that this does not mean that the patient no longer identifies as transgender. Rather, it means that the patient has greater access to themselves, is less threatened by the self-states that have haunted them and no longer needs strong dissociation to maintain internal equilibrium. The result may be that transition is no longer felt to be necessary or, if it is, that the patient will be psychologically more resilient and therefore better able to face the challenges of transition. Both outcomes and their many variations are legitimate.

Psychotherapeutic work with homosexuality and trans

In this paper, I argue that contemporary psychoanalytic psychotherapy for young transgender people or those experiencing gender dysphoria bears no relation to the coercive, "directive-suggestive" approach recommended for homosexual patients in the twentieth century. Psychotherapeutic and psychoanalytic approaches have changed dramatically, particularly with regard to the democratisation of the therapeutic relationship and the erosion of the analyst's authority. The kind of analytic authority that coercive conversion therapies hinged on is becoming increasingly rare, and patients expect a more collaborative therapeutic relationship. The argument that therapies which explore the unconscious

[3]Mitchell was not writing about transgender; however, his overall thesis applies equally to trans as it does to homosexuality, as my insertion of the word [transgender] shows.

formation of trans experience are conversion therapies rests on the false assumption that exploring psychodynamics is inherently pathologising. Contemporary analysts argue that all gender, whether conventional or trans, is a manifestation of something else, including, in some cases, trauma. Thinking about the constitutive role of trauma and other dynamic factors can help articulate the textures and complexity of individual transgender subjectivity and need not imply psychopathology (Saketopoulou and Pellegrini 2023).

There is a widespread assumption that homosexuality and trans identities are similar, as they are both considered to be part of the spectrum of human sexual and gender diversity. This assumed similarity is perhaps best illustrated by the widespread penetration of the abbreviation "LGBTQIA+" into our cultural psyche. Given this presumed equivalence between gay and trans, it would seem that the general therapeutic approach should be similar for both groups: treatment should affirm the patient's authentic self, whether this be their sexual orientation or gender identity. However, while both groups experience marginalisation and stigma, when it comes to the phenomenology and psychotherapeutic exploration of gay and trans experience, it turns out that they are both similar and different.

The socialisation of proto-gay youth frequently involves an internalisation of negative cultural attitudes and hostility towards homosexuality and gender non-conformity, particularly in the context of peer relationships. This is otherwise known as internalised homophobia and can be understood as a form of identification with the aggressor (Friedman and Downey 1995). Many gay men have wanted to change their sexual orientation to heterosexual but have been unable to do so (Friedman and Downey 2016). Gay patients may experience feelings of self-hatred relating to their same-sex attraction or to other characteristics associated with being gay, such as gendered and temperamental traits. Gay men often feel that their experience of masculinity is deficient or that they are not masculine enough (Corbett 1993; Friedman and Downey 1999). For those with a favourable developmental history, this self-hatred may be "layered over" earlier self-acceptance (Friedman and Downey 1995). In their seminal paper, Friedman and Downey argue that for others, this self-hatred is actually a condensation of ambivalent relational experiences that occurred in early childhood. They write that these experiences "may be packaged as it were in the conscious mind under the rubric that therapists term "internalised homophobia"" (1995, 91). They argue that individuals with adverse developmental experiences, or primary psychological difficulties, may ultimately attribute all negative feelings about the self to being gay or lesbian. This provides a way to make sense of lifelong experiences of alienation and psychic pain. In short, gay patients may experience their sexual desire as a hated and shame-infused part of the self - a carrier for other, earlier relational and developmental complexities. They may try to eliminate this part of the self, which is experienced as holding painful self-experience, by adopting the heterosexual behaviours and role that they understand to be acceptable in our culture.

The therapeutic approach to homosexual patients today involves helping them accept and own a part of the self that is ambivalently held, hated or infused with shame. Some patients may simply require support, while those with more complex internal difficulties may need a more exploratory psychotherapeutic approach. Friedman and Downey (1995) observed that some patients deteriorate when attempts are made to help them accept their same-sex attraction and ameliorate internalised homophobia. They argue that affirming responses threaten the patient's symptom – internalised homophobia –

which is needed to keep more painful feelings and deeper self-hatred at bay. They suggest that therapists ask, "What is it about giving up these particular symptoms that patients find threatening?" and that the symptoms may be a way of maintaining a needed tie to childhood attachment figures. Ultimately, psychological integration involves transforming the patient's conflicted same-sex desire into "feels like me" but also the capacity to bear the more complex and painful experiences that have formed an amalgam with the unwanted sexual orientation.

Many patients with gender dysphoria or trans identities describe an internal struggle with a gendered part of the self that is infused with painful negative affects. They may experience distress about their sexed body and/or the gender role/identity with which they feel they must comply. Many report experiences of horror, disgust, shame and rage when they become aware of any reminder of their natal sex/gender. For example, a natal female with gender dysphoria may feel shame, disgust and hatred towards her primary and secondary sex characteristics and/or may experience the social norms she believes she is expected to conform to as a female as degrading and highly aversive. Gender-affirming interventions, such as social transition, and hormonal and surgical interventions, can alter, conceal or eliminate the aspects of gendered embodiment and role that evoke these painful feelings. Most clinical guidelines for treating gender dysphoria recommend that clinicians affirm the patient's experienced or desired gender (Coleman et al. 2022; Endocrine Society 2024; Telfer et al. 2018). This necessarily means helping them distance themselves from the natal sex/gender. However, this could work *against* integration, fortifying internal divisions and dissociation. Similarly to how Friedman and Downey (1995) observed that complex developmental (psychodynamic) processes may be folded into internalised homophobia, it is highly likely that for some patients, the unwanted sex/gender is a carrier - for and an attempt to manage - yet-to-be-formulated psychodynamic complexities. If we follow Friedman and Downey's approach, to help our patients find relief from the distress of gender dysphoria, it is necessary to explore what is condensed into or amalgamated with gendered experience. While affirmation should ideally not preclude exploration, detransitioners' experiences suggests otherwise (Littman 2021; Vandenbussche 2022). Reflecting on when we are colluding with an attempt to eliminate a part of the self is crucial in this work, as it is in all psychoanalytic treatment.

One of the most profound differences between homosexuality and gender dysphoria in a psychotherapeutic context is arguably this. With homosexuality, we help the person to accept a hated or feared part of the self. However, when it comes to gender dysphoria, without adequate psychotherapeutic exploration, we essentially collude with the elimination of the hated part – i.e. the natal sex/gender and everything it might represent or carry. Following this line of thought, homosexuality and trans experiences are not equivalent, despite what popular discourse might suggest. While both involve an internal struggle with a part of the self that is ambivalently held, hated or feared, our response to each is diametrically opposed. In terms of internal dynamics, gender dysphoria is closer to internalised homophobia or ego-dystonic homosexuality.

In the past, gay men sought treatment to rid themselves of their "gay" self. Are some trans patients not doing the same when they seek our assistance to get rid of their natal gendered self? If we collude with this, are we not in fact doing what conversion therapists did to homosexuals? Is gender affirmation, in its simplistic but widely practised form,

actually akin to gay conversion therapy? While it might indeed turn some gay people into straight trans people, this is not what I am referring to. The problematic similarity is that gender-affirming care may facilitate an attempt to erase a part of the self. By colluding with the erasure of a part of the self, patients are deprived of an opportunity to explore and work through the unformulated, sequestered components woven into their gendered experience that will likely continue to be ongoing sources of symptoms and suffering if left unaddressed. Outcome studies appear to support this: when it comes to youth, researchers have noted that gender-affirming interventions on their own are insufficient to improve functioning, relieve psychiatric problems or reduce suicidality (Kaltiala et al. 2020; Ruuska et al. 2024).

In essence, just as homosexuality or internalised homophobia may be a way of making sense of, defending against, and attempting to work through psychodynamic complexities, so too is gender dysphoria. News of the availability of sex-reassignment technologies in the 1950s was rapidly followed by a spike in demand for these interventions (Mumford 2023). It is possible to speculate that the availability of sex-altering interventions provided a way of making sense of somatic and unformulated distress, whilst also offering a concrete way of attempting to work through these issues, promising profound transformation and relief. How many gay men would have taken a drug that made them straight to relieve them of their internal struggle with same-sex attraction, if such a drug had been available? Such a drug is not available, so trans and gender-dysphoric patients differ from those with ego-dystonic homosexuality in one very important way: their attempts to metabolise and work through conflicts via gender potentially expose them to serious medical procedures with irreversible effects and significant risks. Gozlan (2025) suggests this kind of argument is based on a hierarchy of identities in which homosexuality is preferable to transgender. However, this obfuscates the main point.

The issue at hand is maintaining a healthy, functioning body that is not exposed to pharmaceuticals with known risks (such as cancer and heart disease) or surgical complications (such as urinary incontinence, impaired sexual function and death) (see D'Angelo 2025). Further compounding the problem is the fact that there is evidence that patients and clinicians are being misled about the benefits and safety of these interventions (Block 2024; McDeavitt 2025; McDeavitt, Cohn, and Kulatunga-Moruzi 2025a; McDeavitt, Cohn, and Levine 2025b; The Economist 2024) with the Federal Trade Commission now investigating possible consumer fraud (Holyoak 2025). I believe that we have an ethical responsibility to offer our young trans patients alternative approaches to increasingly disputed, irreversible medical and surgical interventions, safe and effective alternatives that may relieve their suffering and therefore the need for these procedures. This is particularly important at a time when the benefits of these interventions for this population are increasingly being questioned worldwide (Cass 2024a; Drobnič Radobuljac et al. 2024; Kozlowska et al. 2024).

Psychoanalytic arrogance: Ignoring empirical science

In my recent paper "Do We Want to Know?" (D'Angelo 2025), I began to consider what might be happening within our profession that has led to the marginalisation and persecution of certain clinical voices in relation to gender. The paper examines how the current wave of political activism, infusing psychoanalytic theorising, determines the allowable

discourse in relation to gender and trans identities. Asking "why" in relation to transgender identity has become off-limits, and doing so puts clinicians at risk of breaching conversion therapy legislation in many jurisdictions. I explore how this shapes clinical interaction, mirroring and reinforcing the prohibitions on knowing and resistances to exploration that patients with gender distress bring to treatment. I also discuss the controversial nature of the evidence base for paediatric gender transition, which increasingly raises questions about whether the potential benefits of these interventions outweigh the known risks. In light of this uncertainty, I argue that sensitive, detailed and nuanced psychoanalytic exploration is essential to enable young people to make a decision that is as fully informed as possible, considering the range of potential conscious and unconscious motivations at play. Much of the paper outlines the bias pervading the psychoanalytic literature on the subject, which generally ignores the risks of harm. I document numerous examples of analysts challenging the mainstream approach to gender dysphoria and demonstrate how their work is misrepresented and distorted to discredit it. Finally, I suggest what might be going on unconsciously in the analytic community to account for these observations.

As both a psychiatrist and a scientist, as well as a psychoanalyst, I recognise the power of psychoanalysis to explore individual subjectivity *and also* value the real-world hard data of science that can inform our clinical decisions. My respect for evidence-based medicine and the value of high-quality research data leaves me no choice but to argue for caution regarding the current medicalised treatment model for young people with gender distress. This position has led to multiple attempts to discredit my work either through misrepresentation, arguing that I am a conversion therapist, or by claiming that I am a eugenicist seeking to eliminate trans people (D'Angelo 2025). My cautious approach is informed by my extensive reading of the outcome literature on gender transition. In particular, the growing body of systematic reviews concludes that the evidence for benefits is weak and uncertain, while the risks are established and real (Baker et al. 2021; Hall et al. 2024; Ludvigsson et al. 2023; Miroshnychenko et al. 2024; Miroshnychenko, Ibrahim, et al. 2025; Miroshnychenko, Roldan, et al. 2025; National Institute for Health and Care Excellence 2021a, 2021b; Taylor et al. 2024a; Taylor et al. 2024b; Zepf et al. 2024). I see this data from clinical populations as an important part of the overall situation in which our clinical work with trans patients takes shape.

Two of the most problematic psychoanalytic attitudes that have led to our field becoming increasingly marginalised and irrelevant are: (i) psychoanalytic elitism about what constitutes "real" psychoanalysis, and (ii) rejection of the sciences and the scientific method. These attitudes have insulated psychoanalysis from debate and have blocked the consideration of new information that could have led to theoretical revisions and safer, more effective ways of practising our craft. With regard to our profession's history with homosexuality, these attitudes have caused significant harm to our patients and our profession by perpetuating unhelpful theories and harmful therapeutic approaches. Many gay analysands reported not only that they were not helped, but that they were harmed by psychoanalytic treatments which attempted to change their sexual orientation (Davison and Walden 2024). Stoller noted that one of the tactics that allowed the prevailing views about homosexuality to persist for as long as they did was to suggest that "colleagues we disagree with are not practising analysis, or are not analysts" (Isay and Friedman 1986, 199).

A recent critique of my work (Gozlan 2025) demonstrates how these tactics can be deployed to constrain psychoanalytic discourse and to discredit "colleagues we disagree with". Firstly, the author claims to know what constitutes "real" psychoanalysis with trans people, and claims that my ideas constitute a simplistic and naive simulacrum of psychoanalysis. Secondly, he claims that referring to the scientific outcome data when working with trans patients is a "category error" and that outcome data is not relevant to the practice of psychoanalysis. Consistent with this stance, the author completely sidesteps one of the most significant issues raised in the paper he is critiquing: the growing number of systematic reviews that increasingly highlight the uncertainty of the benefits of medical and surgical gender transition for young people. He claims that psychoanalysis is concerned with individual subjects, not clinical populations: science and empirical evidence should stay outside of the consulting room.

This conspicuous absence of any attempt to engage with the outcome data is apparent in most of the contemporary psychoanalytic literature on this topic. For example, in a recent 180-page publication on transgender experience, *Gender without Identity* (Saketopoulou and Pellegrini 2023), medical interventions warrant only the scantest of mentions. The word "hormone" appears twice, and "surgery" appears once in the entire book, both mentioned casually in a section exploring the "mix and match" "embodied possibilities" of non-binary genders. There is no engagement whatsoever with the hard data of science: outcome studies and systematic reviews examining the medical technologies frequently sought by transgender young people are ignored. Similarly, in a recent volume of *The Psychoanalytic Study of the Child* featuring six papers on transgender children, not a single one engages with the medical realities, in particular the outcome data for medical interventions (Gozlan 2022; Gozlan et al. 2022; Osserman and Wallerstein 2022; Silber 2022; Watson 2022; Wiggins 2022).

A recent paper, "Transgender – A Challenge for Psychoanalysis" (Gullestad 2024), only mentions medical interventions in the context of clinicians' inability to predict future regret, because psychoanalysts "are not fortune tellers". The dismissive quality of this statement is troubling given the serious implications of medical and surgical gender-modifying interventions. The author seems to believe that attempting to study outcomes to help identify who will benefit, and by how much, and who will be harmed, is a fool's errand. As with the other references cited above, what the data actually tells us about the likely benefits of these interventions is omitted. The absence of any acknowledgement of, or reflection on, empirical outcome data so prevalent in most psychoanalytic writing on the subject can only be interpreted as evidence of psychoanalysis' ongoing negation and rejection of empirical science. This attitude, coupled with elitist posturing, is precisely what shaped our shameful history in relation to homosexuality.

It is particularly troubling to observe this defensive dynamic at play in relation to gender. Medical and surgical interventions are often integral to the lives of trans people. Whilst psychoanalytic exploration attempts to illuminate the hopes, meanings and affects that infuse the need for these interventions, medical and surgical procedures do not exist solely in the psychological realm or the world of intrapsychic fantasy. They have very real impacts on the body, health, sexuality, reproductive capacity and longevity. Especially today when the majority of psychoanalysts are no longer medically trained, surely engagement with empirical data is an essential component of ethical practice if

we are to help our patients navigate how they will ultimately live and embody their gendered experience.

In my work, awareness of the outcome data becomes part of my internal process of reflection as I think about the actual steps and interventions my patients may take or seek as a result of their psychic distress. While some may disagree, concern about a young person seeking body modification or genital surgery is grounded in reality and is not simply transphobic countertransference. It is misleading to suggest that such caution cannot coexist with detailed analytic exploration. In his critique, Gozlan (2025) creates an artificial and false distinction suggesting that our ability to listen to patients can be quarantined from the realities of the real world by a cordon sanitaire. He is implicitly claiming a kind of neutrality that he believes I lack, which is a variation on his main claim that I am not psychoanalytic enough. We now fully accept that the analyst's subjectivity can never be quarantined from the clinical interaction and always contributes, to a greater or lesser extent, to the shaping of any intervention. Undoubtedly, our personal understanding of the benefits and harms of gender transition profoundly impacts how we hear and respond to clinical material from our gender-distressed patients. The clinical responses of analysts who wholeheartedly believe that gender-affirming medical interventions are "life-saving" will have a different quality and tone to the responses of analysts like me who have carefully read the outcome studies.

I reiterate that there is no reliable evidence that these treatments are life-saving (Cass 2024b, 187). It would be disingenuous to argue that any analyst can prevent their own position on medical gender-affirming interventions from influencing the analytic interpersonal field. Similarly, it is implausible to suggest that anyone working with trans-identified youth could be neutral on the incredibly polarising and emotionally saturated issue of medical gender-affirming interventions. Adopting the position that gender-affirming interventions are proven, established, safe and life-saving is *not* a neutral position. Refusing to reflect on whether these interventions are safe and beneficial, or harmful, is certainly not neutral either.

Yet I believe there is an even more compelling argument that analysts should engage with empirical science when it is relevant to their clinical work and their patient's specific circumstances. Whilst the power of psychoanalysis derives from its focus on the unique intersubjective process occurring within a specific analytic dyad, for this process to be helpful, it requires the presence of a third position. Without a third position, patient and analyst may remain endlessly mired either in collusion or repetitive enactments and projective processes that do not lead to expanded awareness, greater freedom or clinical change. Stern (2004) has referred to this rigidity of relatedness as "the grip of the field", a development on Wolstein's "transference–countertransference interlock". While there are many ways of understanding and constituting an analytic third, including the analyst's relation to theory (Britton 1989), or a shared, intersubjective third (Benjamin 2004) or via the fostering of mentalisation (Fonagy et al. 2002), loosening the dyadic collusion/interlock by introducing a third position is essential for analytic progress.

The hard data of science, which exists outside of the analytic dyad, can arguably be considered a different kind of third. The exploration of gendered experience can involve the dismantling of existing ways of thinking about the self, the body and what it means to be human. Whilst this presents us with an exhilarating portal to heretofore unimagined possibilities, it also potentially facilitates a world underpinned by a form of

omnipotent thought in which anything is possible. When applied to child development, the metaphor of the swimming pool captures captures how the child cannot explore the new experience of swimming without a bottom or edges to hold onto (Koener and Lebrun 2024). Outcome data can function in the same way – providing "edges" constituted by reality that can serve as a counterpoint to the imaginative and associative process of psychic exploration. The edges might support what is occurring in the dyad, or they might frustrate or challenge it. By keeping the cutting-edge outcome data alive in his mind, the analyst can help ensure the dyad does not drift off into a collusive denial of reality. This is particularly essential in work with gender distress as what is wished for and what exists in fantasy is not always consonant with what is possible in reality.[4] Refusal to engage with objective reality whilst privileging only psychic reality, as seen in much psychoanalytic literature on this topic, is not only arrogant, but arguably reckless.

Psychoanalysis rejects science at its own peril

One of the most polarising and urgent questions facing our field and healthcare more broadly is whether body-altering, sex-trait-modifying endocrine and surgical interventions are safe and effective, particularly for young people. Psychoanalytic writing, and indeed most mainstream publications in the field of psychiatry and psychology, fail to acknowledge that the evidence base for gender-affirming medical interventions is weak and controversial. Instead, the benefits of medicalised gender change are assumed to be an open and shut case. Analysts who unquestioningly support transition misrepresent the evidence base and distort the work of those with different perspectives (D'Angelo 2025). Discrediting the work of those with whom we disagree as not being analytic was a strategy employed by analysts defending their position on homosexuality for decades after it was removed from the DSM. The same tactics are being used today against those who question the gender-affirming medical approach or who seek to explore the psychic organisation and psychodynamics of trans identities (see, for example, Gozlan 2025; Saketopoulou 2022). Like the American Psychological Association and the American Psychiatric Association, the American Psychoanalytic Association has made clear that it fully supports medical transition (American Psychiatric Association 2020; American Psychoanalytic Association 2023; American Psychological Association 2015). In an email circulated to the entire membership of the American Psychoanalytic Association in 2024, the Committee on Gender and Sexuality claimed that groups raising concerns about gender affirming medical care are circulating "disinformation and misinformation". In a striking reversal, so-called attempts to address misinformation have become weaponised as part of a relentless attack on what science is increasingly telling us about adolescent gender transition, and on clinicians who dare to draw attention to the risks.

In an earlier publication, I noted that the harm done to gay people by our profession continued for an extended period, in large part because we psychoanalysts ignored the emerging science (D'Angelo 2023). Psychoanalysis was, and still is, the only medical

[4]Failure to grapple with reality prior to transition may result in psychological breakdown because the desired bodily changes do not bring about the hoped-for internal transformation (D'Angelo 2020; Lemma 2018).

specialty that relied on case studies rather than science (Friedman and Downey 1998). Psychoanalysis developed its own speculative theories, extrapolated from individual cases, which were essentially unfalsifiable because they were never tested by the scientific method. The point is not to discredit the centrality of the case study in psychoanalysis, but to question the tendency to privilege it over empirical data, especially when that data could challenge our favoured theories. The elitist protectionism of the psychoanalytic profession and psychoanalytic institutes meant that any ideas challenging the mainstream were discredited and rejected before they could gain traction. For instance, there was enormous resistance to the notion that psychotropic drugs could be beneficial, with analysts contending that their use would contaminate the unfolding of the transference (Friedman and Downey 1998).

Similarly, psychoanalysis clung to its own idiosyncratic theoretical formulations about homosexuality for decades after Kinsey and other sexologists published their groundbreaking research. Kinsey, Pomeroy, and Martin's 1948 publication challenged psychoanalysis' pathological view of homosexuality by finding that it was far more prevalent than was generally acknowledged (Kinsey, Pomeroy, and Martin 1948). As mentioned previously, Kinsey's empirical findings were met with hostility by psychiatrists in the US, particularly psychoanalysts (Chiang 2008). Psychoanalysts insisted that their clinical experience trumped empirical data, which they considered inferior because it did not take unconscious factors into account.

We are now at another crucial point in the history of psychoanalysis. Contemporary psychoanalytic theory has embraced transgender issues and is committed to protecting transgender people from the pathologising attitudes that homosexuals faced in the twentieth century. Psychoanalytic theorising has aligned itself with political activism, which increasingly determines how gender can be understood and discussed. Exploring the unconscious dynamics of trans identities and gender dysphoria evokes anxiety and guilt regarding how gay patients were treated in the past. Clinicians who advocate psychological exploration, rather than immediate affirmation, are cast as conversion therapists, harming their patients rather than protecting them. Contemporary writers (Gherovici 2017; Gozlan 2011; Hansbury 2017; Harris 2022; Saketopoulou and Pellegrini 2023) are proposing new theoretical models that eschew pathologising formulations. These new psychoanalytic models of trans subjectivity largely incorporate and normalise medical and surgical transition as an integral aspect of trans experience. Determined to avoid a repetition of our history with homosexuality, they engage only superficially with the outcome science, if at all, and gloss over the real risks of harm associated with these interventions, instead foregrounding the liberating possibilities of trans life.

As we speak, contemporary psychoanalytic theorising is colliding with emerging science which suggests that the benefits of these interventions do not outweigh the risks for young people. Yet psychoanalysts remain silent on the issue, or attack those who raise the alarm. These findings should give us pause to consider what this means for our patients and how can we help them to navigate their gendered experiences. Instead, we are witnessing a repetition of history: scientific ideas that challenge the psychoanalytic orthodoxy of the day are consistently discredited and dismissed. While analysts who challenged psychoanalytic orthodoxy in relation to homosexuality received hate mail, including from prominent educators (Downey and Friedman 2008), those who challenge the psychoanalytic hegemony on trans face accusations of right-wing

bias, transphobia and even genocidal intent (McGleughlin 2024; Saketopoulou 2022; Saketopoulou and Pellegrini 2023). Our refusal to seriously consider empirical data means that we are in serious danger of participating in a repetition of our history of harming sexual and gender minorities. If history has anything to teach us, it is that we avoid science at our own peril.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Patient anonymisation

Potentially personally identifying information presented in this article that relates directly or indirectly to an individual, or individuals, has been changed to disguise and safeguard the confidentiality, privacy and data protection rights of those concerned, in accordance with the journal's anonymisation policy.

ORCID

Roberto D'Angelo http://orcid.org/0000-0003-2929-3831

References

American Psychiatric Association. 2020. *Position Statement on Treatment of Transgender and Gender Diverse Youth*. https://www.psychiatry.org/getattachment/8665a2f2-0b73-4477-8f60-79015ba9f815/Position-Treatment-of-Transgender-Gender-Diverse-Youth.pdf.

American Psychoanalytic Association. 2023. *Position Statement Opposing Anti-trans Legislation*. https://apsa.org/wp-content/uploads/2023/05/APsA-Position-Statement-5.30.23.pdf?ver.

American Psychoanalytic Association Committee on Gender and Sexuality. 2023, May. *Message from COGS*. https://drive.google.com/file/d/1-Q19fijGBB7ugNdtXmrGvutRu-ovXTKC/view.

American Psychological Association. 2009. *Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts*. https://www.apa.org/about/policy/sexual-orientation.

American Psychological Association. 2015. "Guidelines for Psychological Practice with Transgender and Gender Nonconforming People." *American Psychologist* 70 (9): 832–864. https://doi.org/10.1037/a0039906.

Ashley, F. 2022. "Interrogating Gender-Exploratory Therapy." *Perspectives on Psychological Science* 18 (2): 472–481. https://doi.org/10.1177/17456916221102325.

Baker, K. E., L. M. Wilson, R. Sharma, V. Dukhanin, K. McArthur, and K. A. Robinson. 2021. "Hormone Therapy, Mental Health, and Quality of Life among Transgender People: A Systematic Review." *Journal of the Endocrine Society* 5 (4): 1–16. https://doi.org/10.1210/jendso/bvab011

Bayer, R. 1981. *Homosexuality and American Psychiatry: The Politics of Diagnosis*. New York: Basic Books.

Beckstead, A. L. 2012. "Can We Change Sexual Orientation?" *Archives of Sexual Behavior* 41 (1): 121–134. https://doi.org/10.1007/s10508-012-9922-x.

Benjamin, J. 2004. "Beyond Doer and Done To: An Intersubjective View of Thirdness." *The Psychoanalytic Quarterly* 73 (1): 5–46. https://doi.org/10.1002/j.2167-4086.2004.tb00151.x.

Bergler, E. 1957. *Homosexuality: Disease or Way of Life?* New York: Hill and Wang.

Bergmann, M. 1945. "Homosexuality on the Rorschach Test." *Bulletin of the Menninger Clinic* 9:78–83.

Block, J. 2024. "Dispute Arises over World Professional Association for Transgender Health's Involvement in WHO's Trans Health Guideline." *BMJ* 387:q2227. https://doi.org/10.1136/bmj.q2227

Britton, R. 1989. "The Missing Link: Parental Sexuality and the Oedipus Complex." In *The Oedipus Complex Today: Clinical Implications*, edited by J. Steiner, R. Britton, M. Feldman, and E. O'Shaughnessy, 83–101. New York: Karnac.

Cass, H. 2024a. *Independent review of gender identity services for children and young people: Final report*. https://webarchive.nationalarchives.gov.uk/ukgwa/20250310143933/https://cass.independent-review.uk/home/publications/final-report/.

Cass, H. 2024b, May 16. *Independent review of gender identity services for children and young people: Adult gender dysphoria clinics*. https://www.england.nhs.uk/wp-content/uploads/2024/08/PRN01451-letter-from-dr-cass-to-john-stewart-james-palmer-May-2024.pdf.

Chiang, H. H. 2008. "Effecting Science, Affecting Medicine: Homosexuality, the Kinsey Reports, and the Contested Boundaries of Psychopathology in the United States, 1948–1965." *Journal of the History of the Behavioral Sciences* 44 (4): 300–318. https://doi.org/10.1002/jhbs.20343.

Coleman, E., A. E. Radix, W. P. Bouman, G. R. Brown, A. L. De Vries, M. B. Deutsch, R. Ettner, et al. 2022. "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8." *International Journal of Transgender Health* 23 (sup1): S1–S259. https://doi.org/10.1080/26895269.2022.2100644

Corbett, K. 1993. "The Mystery of Homosexuality." *Psychoanalytic Psychology* 10 (3): 345–357. https://doi.org/10.1037/h0079466

D'Angelo, R. 2020. "The man I Am Trying to Be Is Not Me." *The International Journal of Psychoanalysis* 101 (5): 951–970. https://doi.org/10.1080/00207578.2020.1810049.

D'Angelo, R. 2023. "Supporting Autonomy in Young People with Gender Dysphoria: Psychotherapy Is Not Conversion Therapy." *Journal of Medical Ethics* 51 (1): 3–9. https://doi.org/10.1136/jme-2023-109282.

D'Angelo, R. 2025. "Do We Want to Know?" *The International Journal of Psychoanalysis* 106 (1): 82–108. https://doi.org/10.1080/00207578.2024.2395964.

Davison, G. C., and K.-R. Walden. 2024. "History and Iatrogenic Effects of Conversion Therapy." *Annual Review of Clinical Psychology* 20 (1): 333–354. https://doi.org/10.1146/annurev-clinpsy-080822-052144.

Downey, J. I., and R. C. Friedman. 2008. "Homosexuality: Psychotherapeutic Issues." *British Journal of Psychotherapy* 24 (4): 429–468. https://doi.org/10.1111/j.1752-0118.2008.00099.x.

Drescher, J. 2008. "A History of Homosexuality and Organized Psychoanalysis." *The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry* 36 (3): 443–460. https://doi.org/10.1521/jaap.2008.36.3.443.

Drescher, J. 2015. "Can Sexual Orientation Be Changed?" *Journal of Gay & Lesbian Mental Health* 19 (1): 84–93. https://doi.org/10.1080/19359705.2014.944460.

Drescher, J. 2023. "Informed Consent or Scare Tactics? A Response to Levine et al.'s 'Reconsidering Informed Consent for Trans-identified Children, Adolescents, and Young Adults'." *Journal of Sex & Marital Therapy* 49 (1): 99–107. https://doi.org/10.1080/0092623X.2022.2080780.

Drobnič Radobuljac, M., U. Grošelj, R. Kaltiala, M. Drobnič Radobuljac, R. Vermeiren, D. Anagnostopoulos, F. Çuhadaroglu Çetin, et al. 2024. "ESCAP Statement on the Care for Children and Adolescents with Gender Dysphoria: An Urgent Need for Safeguarding Clinical, Scientific, and Ethical Standards." *European Child & Adolescent Psychiatry* 33 (6): 2011–2016. https://doi.org/10.1007/s00787-024-02440-8.

Endocrine Society. 2024, August 5. *Endocrine Society Statement in Support of Gender-Affirming Care*. Endocrine Society. https://www.endocrine.org/news-and-advocacy/news-room/2024/statement-in-support-of-gender-affirming-care.

Fonagy, P., G. Gergeley, E. Jurist, and M. Target. 2002. *Affect Regulation, Mentalization, and the Development of the Self*. London: Routledge.

Friedman, R. C., and J. Downey. 1995. "Internalized Homophobia and the Negative Therapeutic Reaction." *Journal of the American Academy of Psychoanalysis* 23 (1): 99–113. https://doi.org/10.1521/jaap.1.1995.23.1.99.

Friedman, R. C., and J. I. Downey. 1998. "Psychoanalysis and the Model of Homosexuality as Psychopathology: A Historical Overview." *The American Journal of Psychoanalysis* 58 (3): 249–270. https://doi.org/10.1023/A:1022583223820

Friedman, R. C., and J. I. Downey. 1999. "Internalized Homophobia and Gender-Valued Self Esteem in the Psychoanalysis of Gay Patients." *Psychoanalytic Review* 86 (3): 325–347.
Friedman, R. C., and J. I. Downey. 2016. "Editorial: Psychoanalytic Bias against Homosexuality: Reflections on the 1970s." *Psychodynamic Psychiatry* 44 (3): 339–354. https://doi.org/10.1521/pdps.2016.44.3.339
Gherovici, P. 2017. *Transgender Psychoanalysis*. New York: Routledge.
Gozlan, O. 2011. "Transsexual Surgery: A Novel Reminder and a Navel Remainder." *International Forum of Psychoanalysis* 20 (1): 45–52. https://doi.org/10.1080/0803706x.2010.537695.
Gozlan, O. 2022. "Gender as Lint Collector." *The Psychoanalytic Study of the Child* 75 (1): 173–178. https://doi.org/10.1080/00797308.2021.1975458.
Gozlan, O. 2025. "Unmasking the Moral Fantasy of the 'Underlying Conflict': A Critique of Roberto D'Angelo's 'Do We Want to Know?'." *The International Journal of Psychoanalysis* 106 (4): 849–850. https://doi.org/10.1080/00207578.2025.2511307.
Gozlan, O., J. Osserman, L. Silber, H. Wallerstein, E. Watson, and T. Wiggins. 2022. "Transgender Children: From Controversy to Dialogue." *The Psychoanalytic Study of the Child* 75 (1): 198–214. https://doi.org/10.1080/00797308.2021.1975462.
Gullestad, S. E. 2024. "Transgender – a Challenge for Psychoanalysis?" *The Scandinavian Psychoanalytic Review* 47 (2): 129–136. https://doi.org/10.1080/01062301.2024.2432050.
Haldeman, D. C. 1991. "Sexual Orientation Conversion for Gay Men and Lesbians." In *Homosexuality: Research Implications for Public Policy*, edited by J. C. Gonsiorek and J. D. Weinrich, 149–160. Newbury Park: Sage Publications.
Hall, R., J. Taylor, C. E. Hewitt, C. Heathcote, S. W. Jarvis, T. Langton, and L. Fraser. 2024. "Impact of Social Transition in Relation to Gender for Children and Adolescents: A Systematic Review." *Archives of Disease in Childhood* 109: s12–s18. https://doi.org/10.1136/archdischild-2023-326112.
Hansbury, G. 2017. "Unthinkable Anxieties." *TSQ: Transgender Studies Quarterly* 4 (3–4): 384–404. https://doi.org/10.1215/23289252-4189883.
Harris, A. 2022. "Transgender and Analytic Countertransference." *The Psychoanalytic Review* 109 (3): 277–286. https://doi.org/10.1521/prev.2022.109.3.277.
Hoffman, I. 1992. "Some Practical Implications of a Social-Constructivist View of the Psychoanalytic Situation." *Psychoanalytic Dialogues* 2 (3): 287–304. https://doi.org/10.1080/10481889209538934
Holyoak, M. 2025, July 9. Commissioner Holyoak's Prepared Remarks for the FTC Workshop on Exploring Unfair or Deceptive Trade Practices in "Gender-Affirming Care" for Minors. Federal Trade Commission. https://www.ftc.gov/news-events/news/speeches/commissioner-holyoaks-prepared-remarks-ftc-workshop-exploring-unfair-or-deceptive-trade-practices.
Hooker, E. 1957. "The Adjustment of the Male Overt Homosexual." *Journal of Projective Techniques* 21 (1): 18–31. https://doi.org/10.1080/08853126.1957.10380742.
Hooker, E. 1958. "Male Homosexuality in the Rorschach." *Journal of Projective Techniques* 22 (1): 33–54. https://doi.org/10.1080/08853126.1958.10380822.
Isay, R. 1985. "On the Analytic Therapy of Homosexual Men." *Psychoanalytic Study of the Child* 40:235–254. https://doi.org/10.1080/00797308.1985.11823031
Isay, R., and R. Friedman. 1986. "Toward a Further Understanding of Homosexual Men." *Journal of the American Psychoanalytic Association* 34 (1): 193–206. https://doi.org/10.1177/000306518603400110.
Kaltiala, R., E. Heino, M. Työläjärvi, and L. Suomalainen. 2020. "Adolescent Development and Psychosocial Functioning after Starting Cross-sex Hormones for Gender Dysphoria." *Nordic Journal of Psychiatry* 74 (3): 213–219. https://doi.org/10.1080/08039488.2019.1691260
Kinsey, A. C., W. B. Pomeroy, and C. E. Martin. 1948. *Sexual Behaviour in the Human Male*. Philadelphia: Saunders.
Koener, B., and J.-P. Lebrun. 2024. *Changer de Genre? Comment le Malentendu Opere Chez les Jeunes … .et les Moins Jeunes*. Paris: Campagne premiere.
Kozlowska, K., G. R. Ambler, S. Dechêne, M. C. A. Almaraz, C. Eliacheff, and K. Entwistle. 2024. "Evolving National Guidelines for the Treatment of Children and Adolescents with Gender Dysphoria: International Perspectives." *Human Systems* 5 (2): 89–152. https://doi.org/10.1177/26344041241269.

Lemma, A. 2018. "Trans-itory Identities: Some Psychoanalytic Reflections on Transgender Identities." *The International Journal of Psychoanalysis* 99 (5): 1089–1106. https://doi.org/10.1080/00207578.2018.1489710.

Lewes, K. 1988. *The Psychoanalytic Theory of Male Homosexuality*. New York: Meridian.

Littman, L. 2021. "Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners." *Archives of Sexual Behavior* 50 (8): 3353–3369. https://doi.org/10.1007/s10508-021-02163-w.

Ludvigsson, J. F., J. Adolfsson, M. Höistad, P. A. Rydelius, B. Kriström, and M. Landén. 2023. "A Systematic Review of Hormone Treatment for Children with Gender Dysphoria and Recommendations for Research." *Acta Paediatrica* 112 (11): 2279–2292. https://doi.org/10.1111/apa.16791.

McDeavitt, K. 2025. "Citation Issues in the American Academy of Pediatrics Policy Statement on Transgender and Gender-Diverse Children and Adolescents (Rafferty, 2018)." *Archives of Sexual Behavior* 54: 1297–1305. https://doi.org/10.1007/s10508-025-03106-5.

McDeavitt, K., J. Cohn, and C. Kulatunga-Moruzi. 2025a. "Pediatric Gender Affirming Care Is Not Evidence-Based." *Current Sexual Health Reports* 17 (12): 1–23. https://doi.org/10.1007/s11930-025-00404-w.

McDeavitt, K., J. Cohn, and S. B. Levine. 2025b. "Critiques of the Cass Review: Fact-Checking the Peer-Reviewed and Grey Literature." *Journal of Sex & Marital Therapy* 51: 1–25. https://doi.org/10.1080/0092623X.2025.2455133.

McGleughlin, J. 2024. "Transgender Imagining and the Danger of Normative Theory." *Studies in Gender and Sexuality* 25 (2): 129–142. https://doi.org/10.1080/15240657.2024.2346458.

Meares, R. 1977. "The Persecutory Therapist." *British Journal of Medical Psychology* 50 (4): 349–359. https://doi.org/10.1111/j.2044-8341.1977.tb02433.x.

Miroshnychenko, A., S. Ibrahim, Y. Roldan, C. Kulatunga-Moruzi, S. Montante, R. Couban, G. Guyatt, and R. Brignardello-Petersen. 2025. "Gender Affirming Hormone Therapy for Individuals with Gender Dysphoria Aged<26 Years: A Systematic Review and Meta-analysis." *Archives of Disease in Childhood* 110 (6): 437–445. https://doi.org/10.1136/archdischild-2024-327921.

Miroshnychenko, A., Y. Roldan, S. Ibrahim, C. Kulatunga-Moruzi, S. Montante, R. Couban, G. Guyatt, and R. Brignardello-Petersen. 2025. "Puberty Blockers for Gender Dysphoria in Youth: A Systematic Review and Meta-analysis." *Archives of Disease in Childhood* 110 (6): 429–436. https://doi.org/10.1136/archdischild-2024-327909.

Miroshnychenko, A., Y. M. Roldan, S. Ibrahim, C. Kulatunga-Moruzi, K. Dahlin, S. Montante, R. Couban, G. Guyatt, and R. Brignardello-Petersen. 2024. "Mastectomy for Individuals with Gender Dysphoria below 26 Years of age: A Systematic Review and Meta-analysis." *Plastic and Reconstructive Surgery* 155 (6): 915–923. https://doi.org/10.1097/PRS.0000000000011734.

Mitchell, S. A. 1978. "Psychodynamics, Homosexuality, and the Question of Pathology." *Psychiatry* 41 (3): 254–263. https://doi.org/10.1080/00332747.1978.11023981.

Mitchell, S. A. 1981. "The Psychoanalytic Treatment of Homosexuality Some Technical Considerations." *International Review of Psychoanalysis* 8:63–80.

Mitchell, S. A. 1998. "The Analyst's Authority and Knowledge." *Psychoanalytic Quarterly* 67:1–31. https://doi.org/10.1080/00332828.1998.12006029

Mumford, K. 2023. "Ethically Navigating the Evolution of Gender Affirmation Surgery." *AMA Journal of Ethics* 25 (6): E383–E385. https://doi.org/10.1001/amajethics.2023.383.

National Institute for Health and Care Excellence. 2021a, March 11. *Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria*. https://webarchive.nationalarchives.gov.uk/ukgwa/20250310144323/https://cass.independent-review.uk/nice-evidence-reviews/.

National Institute for Health and Care Excellence. 2021b, March 11. *Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria*. National Institute for Health and Care Excellence (NICE);NHS England;NHS Improvement. https://webarchive.nationalarchives.gov.uk/ukgwa/20250310144323/https://cass.independent-review.uk/nice-evidence-reviews/.

Newbigin, J. 2013. "Psychoanalysis and Homosexuality: Keeping the Discussion Moving." *British Journal of Psychotherapy* 29 (3): 276–291. https://doi.org/10.1111/bjp.12035.

Osserman, J., and H. Wallerstein. 2022. "Transgender Children: From Controvery to Dialogue." *The Psychoanalytic Study of the Child* 75 (1): 159–172. https://doi.org/10.1080/00797308 2021.1975432.
Ovesey, L. 1969. *Homosexuality and Pseudohomosexuality*. New York: Science House.
Przeworski, A., E. Peterson, and A. Piedra. 2021. "A Systematic Review of the Efficacy, Harmful Effects, and Ethical Issues Related to Sexual Orientation Change Efforts." *Clinical Psychology: Science and Practice* 28 (1): 81–100. https://doi.org/10.1111/cpsp.12377.
Rado, S. 1940. "A Critical Examination of the Concept of Bisexuality." *Psychosomatic Medicine* 4:459–467. https://doi.org/10.1097/00006842-194010000-00007
Rado, S. 1949. "An Adaptational View of Sexual Behaviour." In *Psychosexual Development in Health and Disease (The Proceedings of the Eighth Annual Meeting of the American Psychopathological Association, Held in New York City, June 1948*), edited by P. H. Hoch and J. Zubin, 159–189. New York: Grune and Stratton.
Riess, B. 1980. "Psychological Tests in Homosexuality." In *Homosexuality: A Modern Reappraisal*, edited by J. Marmor, 296–311. New York: Basic Books.
Ruuska, S.-M., K. Tuisku, T. Holttinen, and R. Kaltiala. 2024. "All-cause and Suicide Mortalities among Adolescents and Young Adults Who Contacted Specialised Gender Identity Services in Finland in 1996–2019: A Register Study." *BMJ Mental Health* 27 (1): e300940. https://doi.org/10.1136/bmjment-2023-300940.
Saketopoulou, A. 2022. "On Trying to Pass off Transphobia as Psychoanalysis and Cruelty as "Clinical Logic."." *The Psychoanalytic Quarterly* 91 (1): 177–190. https://doi.org/10.1080/00332828.2022.2056378.
Saketopoulou, A. 2025, April 26. *Against Transantagonism: Towards a Metapsychology for the Flourishing of Trans Children"* [Online seminar].
Saketopoulou, A., and A. Pellegrini. 2023. *Gender without Identity*. New York: The Unconscious in Translation.
Schwartz, D. 2022. "Psychoanalysis' Troubled Encounter with Gay Men: How It Lost Its Way, and How It May Yet Find It." *Journal of Psychohistory and Abstracts* 50 (2): 107–122.
Silber, L. 2022. "What about Children and Gender?" *The Psychoanalytic Study of the Child* 75 (1): 179–183. https://doi.org/10.1080/00797308.2021.1975459.
Silverstein, C. 1991. "Psychological and Medical Treatments of Homosexuality." In *Homosexuality: Research Implications for Public Policy*, edited by J. C. Gonsiorek and J. Weinrich, 101–114. Newbury Park: Sage Publications.
Socarides, C. 1968. *The Overt Homosexual*. New York: Grune and Stratton.
Stern, D. 2004. "The Eye Sees Itself: Dissociation, Enactment, and the Achievement of Conflict." *Contemporary Psychoanalysis* 40 (2): 197–237. https://doi.org/10.1080/00107530.2004.10745828
Stern, D. 2010. *Partners in Thought: Working with Unformulated Experience, Dissociation and Enactment*. New York: Routledge.
Stern, D. 2022. "Feels Like Me: Formulating the Embodied Mind." *Psychoanalytic Inquiry* 42 (4): 232–243. https://doi.org/10.1080/07351690.2022.2059275.
Sullivan, H. S. 1953. *The Interpersonal Theory of Psychiatry*. New York: W.W. Norton and Company.
Taylor, J., A. Mitchell, R. Hall, C. Heathcote, T. Langton, L. Fraser, and C. E. Hewitt. 2024a. "Interventions to Suppress Puberty in Adolescents Experiencing Gender Dysphoria or Incongruence: A Systematic Review." *Archives of Disease in Childhood* 109 (Suppl 2): s33–s47. https://doi.org/10.1136/archdischild-2023-326669.
Taylor, J., A. Mitchell, R. Hall, T. Langton, L. Fraser, and C. E. Hewitt. 2024b. "Masculinising and Feminising Hormone Interventions for Adolescents Experiencing Gender Dysphoria or Incongruence: A Systematic Review." *Archives of Disease in Childhood* 109 (Suppl 2): s48–s56. https://doi.org/10.1136/archdischild-2023-326670.
Telfer, M. M., M. A. Tollit, C. C. Pace, and K. C. Pang. 2018. "Australian Standards of Care and Treatment Guidelines for Transgender and Gender Diverse Children and Adolescents." *Medical Journal of Australia* 209 (3): 132–136. https://doi.org/10.5694/mja17.01044.
The Economist. 2024, June 27. Research Into Trans Medicine Has Been Manipulared. *The Economist*. https://www.economist.com/united-states/2024/06/27/research-into-trans-medicine-Has-Been-manipulated.

Vandenbussche, E. 2022. "Detransition-related Needs and Support: A Cross-Sectional Online Survey." *Journal of Homosexuality* 69 (9): 1602–1620. https://doi.org/10.1080/00918369.2021.1919479.

Watson, E. 2022. "Gender Transitioning and Variance in Children and Adolescents: Some Temporal and Ethical Considerations." *The Psychoanalytic Study of the Child* 75 (1): 184–190. https://doi.org/10.1080/00797308.2021.1975460.

Weston, J. 2016. *Curing sexual deviance: Medical approaches to sexual offenders in England, 1919-1959* [Birkbeck, University of London]. https://eprints.bbk.ac.uk/id/eprint/40188/.

Wheeler, W. M. 1949. "An Analysis of Rorschach Indices of Male Homosexuality." *Rorschach Research Exchange and Journal of Projective Techniques* 13 (2): 97–126. https://doi.org/10.1080/10683402.1949.10381453.

Wiggins, T. 2022. "Listening for Trans Childism in Discursive Concern." *The Psychoanalytic Study of the Child* 75 (1): 191–197. https://doi.org/10.1080/00797308.2021.1975461.

Zepf, F. D., L. König, A. Kaiser, C. Ligges, M. Ligges, V. Roessner, T. Banaschewski, and M. Holtmann. 2024. "Beyond NICE: Aktualisierte Systematische Übersicht zur Evidenzlage der Pubertätsblockade und Hormongabe bei Minderjährigen mit Geschlechtsdysphorie." *Zeitschrift für Kinder – und Jugendpsychiatrie und Psychotherapie* 52 (3): 167–187. https://doi.org/10.1024/1422-4917/a000972.