Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports

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Abstract

Purpose

In on-line forums, parents have been reporting that their children are experiencing what is described here as “rapid-onset gender dysphoria,” appearing for the first time during puberty or even after its completion. The onset of gender dysphoria seemed to occur in the context of belonging to a peer group where one, multiple, or even all of the friends have become gender dysphoric and transgender-identified during the same timeframe. Parents also report that their children exhibited an increase in social media/internet use prior to disclosure of a transgender identity. The purpose of this study was to document and explore these observations and describe the resulting presentation of gender dysphoria, which is inconsistent with existing research literature.

Methods

Recruitment information with a link to a 90-question survey, consisting of multiple-choice, Likert-type and open-ended questions, was placed on three websites where parents had reported rapid onsets of gender dysphoria. Website moderators and potential participants were encouraged to share the recruitment information and link to the survey with any individuals or communities that they thought might include eligible participants to expand the reach of the project through snowball sampling techniques. Data were collected anonymously via SurveyMonkey. Quantitative findings are presented as frequencies, percentages, ranges, means and/or medians. Open-ended responses from two questions were targeted for qualitative analysis of themes.

Results

There were 256 parent-completed surveys that met study criteria. The adolescent and young adult (AYA) children described were predominantly female sex at birth (52.8%) with a mean age of 16.4 years. Forty-one percent of the AYAs had expressed a non-heterosexual sexual orientation before identifying as transgender. Many (62.5%) of the AYAs had been diagnosed with at least one mental health disorder or neurodevelopmental disability prior to the onset of their gender dysphoria (range of the number of pre-existing diagnoses 0–7). In 36.8% of the friendship groups described, the majority of the members became transgender-identified. The most likely outcomes were that AYA mental well-being and parent-child relationships became worse since AYAs “came out”. AYAs expressed a range of behaviors that included: expressing distrust of non-transgender people (22.7%); stopping spending time with non-transgender friends (25.0%); trying to isolate themselves from their families (49.4%), and only trusting information about gender dysphoria from transgender sources (46.6%).

Conclusion

Rapid-onset gender dysphoria (ROGD) describes a phenomenon where the development of gender dysphoria is observed to begin suddenly during or after puberty in an adolescent or young adult who would not have met criteria for gender dysphoria in childhood. ROGD appears to represent an entity that is distinct from the gender dysphoria observed in individuals who have previously been described as transgender. The worsening of mental well-being and parent-child relationships and behaviors that isolate AYAs from their parents, families, non-transgender friends and mainstream sources of information are particularly concerning. More research is needed to better understand this phenomenon, its implications and scope.


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Data Availability: The data cannot be made publicly available due to ethical restrictions. The study participants did not provide consent to have their responses shared publicly, shared in public databases, or shared with outside researchers. Furthermore, due to the sensitive information contained in the data and the politicized and contentious discourse around the study of gender dysphoria, protection of the privacy of the participants responding to the survey is of utmost importance. For any questions about restriction on data sharing, please contact the Program for the Protection of Human Subjects (PPHS) at the Icahn School of Medicine at Mount Sinai (IRB@mssm.edu).

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Introduction

In recent years, a number of parents have been reporting in online discussion groups such as 4thwavenow in the US (https://www.4thwavenow.com) and Transgender Trend in the UK (https://www.transgendertrend.com) that their adolescent and young adult (AYA) children, who have had no histories of childhood gender identity issues, experienced a rapid onset of gender dysphoria. Parents have described clusters of gender dysphoria outbreaks occurring in pre-existing friend groups with multiple or even all members of a friend group becoming gender dysphoric and transgender-identified in a pattern that seems statistically unlikely based on previous research [1–5]. Parents describe a process of immersion in social media, such as “binge-watching” YouTube transition videos and excessive use of Tumblr, immediately preceding their child becoming gender dysphoric. These descriptions are atypical for the presentation of gender dysphoria described in the research literature [1–5] and raise the question of whether social influences may be contributing to or even driving these occurrences of gender dysphoria in some populations of adolescents and young adults. For the purpose of this study, rapid-onset gender dysphoria (ROGD) is defined as a type of adolescent-onset or late-onset gender dysphoria where the development of gender dysphoria is observed to begin suddenly during or after puberty in an adolescent or young adult who would not have met criteria for gender dysphoria in childhood. This study was designed to describe rapid-onset gender dysphoria (ROGD) and to generate hypotheses, including the role of social and peer contagion in the development of this condition.

Background

Gender dysphoria in adolescence.

Gender dysphoria (GD) is defined as an individual’s persistent discomfort with their biological sex or assigned gender [6]. Two types of gender dysphoria studied include early-onset GD, where the symptoms of gender dysphoria begin in early childhood, and late-onset GD where the symptoms begin after puberty [6]. Late-onset GD that occurs during adolescence is now called adolescent-onset GD. The majority of adolescents who present for care for gender dysphoria are individuals who experienced early-onset GD that persisted or worsened with puberty although an atypical presentation has been described where adolescents who did not experience childhood symptoms present with new symptoms in adolescence [2, 7]. Adolescent-onset gender dysphoria is a relatively new phenomenon for natal females. In fact, prior to 2012, there were no little to no research studies about adolescent females with gender dysphoria first beginning in adolescence [5]. Thus, far more is known about adolescents with early-onset gender dysphoria than adolescents with adolescent-onset gender dysphoria [1, 8]. Although not all research studies on gender dysphoric adolescents exclude those with adolescent-onset gender dysphoria [5], it is important to note that most of the studies on adolescents, particularly those about gender dysphoria persistence and desistance rates and outcomes for the use of puberty suppressing hormone therapy, have been conducted in individuals whose gender dysphoria began in childhood. Subjects with adolescent-onset gender dysphoria would not have met inclusion criteria for these studies [9–17]. Therefore, most of the research on adolescents with gender dysphoria to date is not generalizable to adolescents experiencing adolescent-onset gender dysphoria [9–17] and the outcomes for individuals with adolescent-onset gender dysphoria, including persistence and desistance rates and outcomes for treatments, are currently unknown.

As recently as 2012, there were only two clinics (one in Canada and one in the Netherlands) that had gathered enough data to provide empirical information about the main issues for gender dysphoric adolescents [18]. Both institutions concluded that the management of adolescent-onset gender dysphoria is more complicated than the management of early-onset gender dysphoria and that individuals with adolescent-onset are more likely to have significant psychopathology [18]. The presentation of gender dysphoria can occur in the context of severe psychiatric disorders, developmental difficulties, or as part of large-scale identity issues and, for these patients, medical treatment might not be advisable [19]. The APA Task Force on the Treatment of Gender Identity Disorder notes that adolescents with gender dysphoria “should be screened carefully to detect the emergence of the desire for sex reassignment in the context of trauma as well as for any disorder (such as schizophrenia, mania, psychotic depression) that may produce gender confusion. When present, such psychopathology must be addressed and taken into account prior to assisting the adolescent’s decision as to whether or not to pursue sex reassignment or actually assisting the adolescent with the gender transition.” [18].

Social and peer contagion.

The description of cluster outbreaks of gender dysphoria occurring in pre-existing groups of friends and increased exposure to social media/internet preceding a child’s announcement of a transgender identity raises the possibility of social and peer contagion. Social contagion [20] is the spread of affect or behaviors through a population. Peer contagion, in particular, is the process where an individual and peer mutually influence each other in a way that promotes emotions and behaviors that can potentially undermine their own development or harm others [21]. Peer contagion has been associated with depressive symptoms, disordered eating, aggression, bullying, and drug use [21, 22]. Internalizing symptoms such as depression can be spread via the mechanisms of co- contamination, which entails the repetitive discussion of problems, excessive reassurance seeking (ERS), and negative feedback [21, 23–25]. Deviance training, which was first described for rule breaking, delinquency, and aggression, is the process whereby attitudes and behaviors associated with problem behaviors are promoted with positive reinforcement by peers [26, 27].

Peer contagion has been shown to be a factor in several aspects of eating disorders. There are examples in the eating disorder and anorexia nervosa literature of how both internalizing symptoms and behaviors have been shared and spread via peer influences [28–32] which may have relevance to considerations of rapid-onset gender dysphoria. Friendship cliques can set the norms for preoccupation with one’s body, one’s body image, and techniques for weight loss, and can predict an individual’s body image concerns and eating behaviors [28–30]. Peer influence is intensified in inpatient and outpatient treatment settings for patients with anorexia and counter-therapeutic subcultures that actively promote the beliefs and behaviors of anorexia nervosa have been observed [30–32]. In these settings, there is a group dynamic where the “best” anorexics (those who are thinnest, most resistant to gaining weight, and who have experienced the most medical complications from their disease) are admired, validated, and seen as authoritative by the patients who want to recover from anorexia and cooperate with medical treatment are maligned, ridiculed, and marginalized [30–32]. Additionally, behaviors associated with deceiving parents and doctors about eating and weight loss, referred to as the “anorexic tricks,” are shared by patients in a manner akin to deviance training [30–32]. Online environments provide ample opportunity for excessive reassurance seeking, co- rumination, positive and negative feedback, and deviance training from peers who subscribe to unhealthy, self-harming behaviors. The pro-eating disorder sites provide motivation for extreme weight loss (anorexia), bulimia nervosa, and drug use [21, 22]. Icons that promote validation of eating disorder as an identity, and offer “tips and tricks” for weight loss and for deceiving parents and doctors so that individuals may continue their weight-loss activities [33–35]. If similar mechanisms are at work in the context of gender dysphoria, this greatly complicates the evaluation and treatment of impacted AYAs.

In the past decade, there has been an increase in visibility, social media, and user-generated online content about transgender issues and transition [36], which may act as a double-edged sword. On the one hand, an increase in visibility has given a voice to individuals who would have been under-diagnosed and undertreated in the past [36]. On the other hand, it is plausible that online
content may encourage vulnerable individuals to believe that nonspecific symptoms and vague feelings should be interpreted as gender dysphoria stemming from a transgender condition. Recently, leading international academic and clinical commentators have raised the question about the role of social media and online content in the development of gender dysphoria [37]. Concern has been raised that adolescents may come to believe that transition is the only solution to their individual situations, that exposure to internet content that is uncritically positive about transition may intensify these beliefs, and that those Teens may pressure doctors for immediate medical treatment [18]. There are many examples on popular sites such as Reddit (www.reddit.com with subreddit ask/transgender) and Tumblr (www.tumblr.com) where online advice promotes the idea that nonspecific symptoms should be considered to be gender dysphoria, conveys an urgency to transition, and instructs individuals how to deceive parents, doctors, and therapists to obtain hormones quickly [38]. Fig 1 includes examples of online advice from reddit and tumblr.

![Example quotes of online advice from reddit and tumblr.](https://doi.org/10.1371/journal.pone.0202330.g001)

**Purpose.**

Rapid presentation of adolescent-onset gender dysphoria and gender dysphoria cases occurring in clusters of pre-existing friend groups is not consistent with current knowledge about gender dysphoria and has not been described in the scientific literature to date. The purpose of this research is (1) to describe an atypical presentation of gender dysphoria occurring with sudden and rapid onset in adolescents and young adults; and (2) to generate hypotheses about the condition, including the role of social and peer contagion in its development.

**Materials and methods**

The Icahn School of Medicine at Mount Sinai, Program for the Protection of Human Subjects provided approval of research for this project (HSD: 16–00744).

**Participants**

During the recruitment period, 256 parents completed online surveys that met the study criteria. The sample of parents included more women (91.7%) than men (8.3%) and participants were predominantly between the ages of 45 and 60 (66.1%) (Table 1). Most respondents were White (91.4%), non-Hispanic (99.2%), and lived in the United States (71.7%). Most respondents had a Bachelor’s degree (37.5%) or graduate degree (33.1%). The adolescents and young adults (AYAs) described by their parents were predominantly female sex at birth (82.8%) with an average current age of 16.4 years (range, 11–27 years). See Table 2.

![Table 1. Demographic and other baseline characteristics of parent respondents.](https://doi.org/10.1371/journal.pone.0202330.t001)
Table 2. Demographic and other baseline characteristics of AYAs.
https://doi.org/10.1371/journal.pone.0202330.t002

Procedure

A 90-question survey instrument with multiple choice, Likert-type, and open-ended questions was created by the researcher. The survey was designed for parents (respondents) to complete about their adolescent and young adult children. The survey was uploaded onto Survey Monkey (SurveyMonkey, Palo Alto, CA, USA) via an account that was HIPPA-enabled. IRB approval for the study from the Icahn School of Medicine at Mount Sinai in New York, NY was received. Recruitment information with a link to the survey was placed on three websites where parents and professionals had been observed to describe rapid onset of gender dysphoria (4thwave.org, transgender trend, and youth/transcultural/professionals). Website moderators and potential participants were encouraged to share the recruitment information and link to the survey with any individuals or communities that they thought might include eligible participants to expand the reach of the project through snowball sampling techniques. The survey was active from June 29, 2016 to October 12, 2016 (3.5 months) and took 30–60 minutes to complete. Participants completed the survey at a time and place of their own choosing. Data were collected anonymously and stored securely with Survey Monkey.

Participation in this study was voluntary and its purpose was clearly described in the recruitment information. Electronic consent was obtained. Participants had the option to withdraw consent at any time prior to submitting responses. Inclusion criteria were (1) completion of a survey with parental response that the child had a sudden or rapid onset of gender dysphoria; and (2) parental indication that the child’s gender dysphoria began during or after puberty. There was logic embedded in the survey that disqualified surveys that answered “no” (or skipped the question) about whether the child had a sudden or rapid onset of gender dysphoria and 23 surveys were disqualified prior to completion (20 “no” answers and 3 skipped answers). After cleaning the data for the 274 completed surveys, 8 surveys were excluded for not having a sudden or rapid onset of gender dysphoria and 10 surveys were excluded for not having gender dysphoria that began during or after puberty, which left 256 completed surveys for inclusion. As the survey was voluntary there was no refusal or dropout rate.

Measures

Basic demographic and baseline characteristics

Basic demographic and baseline characteristic questions, including parental attitudes about LGBT rights, were included. Parents were asked about their children’s mental health disorders and neurodevelopmental disabilities that were diagnosed before their child’s onset of gender dysphoria as well as during and after. The question, “Has your child been formally identified as academically gifted, learning disabled, both, neither?” was used as a proxy to estimate rates of academic giftedness and learning disabilities. Questions about trauma and non-suicidal/self-injury were also included as were questions about social difficulties described in a previous research study about gender dysphoric adolescents [19].

DSM-5 diagnostic criteria for gender dysphoria in children.

The DSM 5 criteria for gender dysphoria in children (Fig 2) consist of eight indicators of gender dysphoria [39]. To meet criteria for diagnosis, a child must manifest at least six out of eight indicators including the one designated A1, “A strong desire to be the other gender or an insistence that one is the other gender (or some alternative gender different from one’s assigned gender).” Three of the indicators (A1, A7, and A8) refer to desires or dislikes of the child and five of the indicators (A2–A6) are readily observable behaviors and preferences. The eight indicators were simplified for language and parents were asked to note which, if any, their child had exhibited prior to puberty. The requirement of six-month duration of symptoms was not included.

Fig 2. Diagnostic and statistical manual of mental disorders (fifth ed).
Gender dysphoria in children.
Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports

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DSM-5 diagnostic criteria for gender dysphoria in adolescents and adults.

The DSM-5 criteria for gender dysphoria in adolescents and adults (Fig 3) consist of six indicators of gender dysphoria [39]. To meet criteria for diagnosis, an adolescent or adult must manifest at least two of the six indicators. The six indicators were simplified for language, the first indicator was adjusted for a parent to answer about their child, and parents were asked to note which, if any, their child was expressing currently. The requirement of six-month duration of symptoms was not included.

Fig 3. Diagnostic and statistical manual of mental disorders (fifth ed).

Gender dysphoria in adolescents and adults.
https://doi.org/10.1371/journal.pone.0202330.g003

Exposure to friend groups and social media/Internet content.

Survey questions were developed to describe AYA friend groups, including number of friends that became transgender-identified in a similar time period as the AYA, peer group dynamics and behaviors, and exposure to specific types of social media/Internet content and messages that have been observed on sites popular with teens, such as Reddit and Tumblr.

Behaviors, outcomes, clinical interactions.

Survey questions were developed to specifically quantify adolescent behaviors that had been described by parents in online discussions and observed elsewhere. Participants were asked to describe outcomes such as their child's mental well-being and parent-child relationship since becoming transgender-identified. Parents were also asked about experiences with clinicians and their children's disposition regarding steps taken for transition and duration of transgender-identification both for children who were still transgender-identified and for children who were no longer transgender-identified.

Coping with strong or negative emotions.

Two questions about the AYAs' ability to cope with negative and strong emotions were included. One question was "How does your child handle these emotions?" (please select the best answer.) Offered answers were "My child is overwhelmed by strong emotions and goes to great lengths to avoid feeling them," "My child is overwhelmed by strong emotions and tries to avoid feeling them," "My child neither avoids not seeks out strong emotions," "My child tries to seek out situations in order to feel strong emotions," "My child goes to great lengths to seek out situations in order to feel strong emotions," "None of the above," "I don't know." The other question was "How would you rate your child's ability to deal with their negative emotions and channel them into something productive?" An example was given regarding dealing with a low test grade by studying harder for the next test (excellent) or by ignoring it, throwing a tantrum, blaming the teacher or distracting themselves with computer games, alcohol, drugs, etc. (extremely poor). Offered answers were: excellent, good, fair, poor, extremely poor, and I don't know.

Data analysis

Statistical analyses of quantitative data were performed using Excel and custom shell scripts (Unix). Quantitative findings are presented as frequencies, percentages, ranges, means and/or medians. ANOVAs, chi-squared, and t-tests comparisons were used where appropriate using publicly available calculators and p<0.05 was considered significant. Qualitative data were obtained from open text answers to questions that allowed participants to provide additional information or comments. The types of comments and descriptions were categorized, tallied, and reported numerically. Agrounded theory approach was selected as the analytic strategy of choice for handling the qualitative responses because it allowed the researcher to assemble the data in accordance with the salient points the respondents were making without forcing the data into a preconceived theoretical framework of the researcher's own choosing [40]. Illustrative respondent quotes and summaries from the qualitative data are used to illustrate the quantitative results and to provide relevant examples. Two questions were targeted for full qualitative analysis of themes (one question on friend group behaviors and one on clinician interactions). For these questions, a second reviewer with expertise in qualitative methods was engaged (MM). Both the author (LL) and reviewer (MM) independently analyzed the content of the open text answers and identified major themes. Discrepancies were resolved with collaborative discussion and themes were explored and refined until agreement was reached for the final lists of themes. Representative quotes for each theme were selected by LL, reviewed by MM, and agreement was reached.

Results

Baseline characteristics

Baseline characteristics (Table 1) included that the vast majority of parents favored gay and lesbian couples' right to legally marry (85.0%) and believed that transgender individuals deserve the same rights and protections as other individuals in their country (88.2%). Along with the sudden or rapid onset of gender dysphoria, the AYAs belonged to a friend group where one or multiple friends became gender dysphoric and came out as transgender during a similar time as they did (21.5%), exhibited an increase in their social media/internet use (19.9%), both (45.3%), neither (5.1%), and didn't know (8.2%). For comparisons, the first three categories will be combined and called "social influence" (86.7%) and the last two combined as "no social influence" (13.3%). Nearly half (47.4%) of the AYAs had been formally diagnosed as academically gifted, 4.3% had a learning disability, 10.7% were

http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0202330

both gifted and learning disabled, and 37.5% were neither. Sexual orientation as expressed by the AYA prior to transgender-identification is listed separately for natal females and fetal males (Table 2). Overall, 41% of the AYAs expressed a non-heterosexual sexual orientation prior to disclosing a transgender-identification.

It is important to note that none of the AYAs described in this study would have met diagnostic criteria for gender dysphoria in childhood (Table 3). In fact, the vast majority (80.4%) had zero indicators from the DSM-5 diagnostic criteria for childhood gender dysphoria with 12.2% possessing one indicator, 3.5% with two indicators, and 2.4% with three indicators. Breaking down these results, for readily observable indicators (A2-6), 83.5% of AYAs had zero indicators, 10.2% had one indicator, 3.9% had two indicators, and 1.2% had three indicators. For the desire/dislike indicators (A1, A7, A8), which a parent would have knowledge of if the child expressed them verbally, but might be unaware if a child did not, 95.7% had zero indicators and 3.5% had one indicator. Parents responded to the question about which, if any, of the indicators of the DSM criteria for adolescent and adult gender dysphoria their child was experiencing currently. The average number of positive current indicators was 3.5 (range 0–6) and 83.2% of the AYA sample was currently experiencing two or more indicators. Thus, while the focal AYAs did not experience childhood gender dysphoria, the majority of those who were the focus of this study were indeed gender dysphoric at the time of the survey completion.

Table 3. DSM 5 Indicators for gender dysphoria.
https://doi.org/10.1371/journal.pone.0202330.t003

The AYAs who were the focus of this study had many comorbidities and vulnerabilities predating the onset of their gender dysphoria, including psychiatric disorders, neurodevelopmental disabilities, trauma, non-suicidal self-injury (NSSI), and difficulties coping with strong or negative emotions (Table 4). The majority (62.5%) of AYAs had one or more diagnoses of a psychiatric disorder or neurodevelopmental disability preceding the onset of gender dysphoria (range of the number of pre-existing diagnoses 0–7). Many (49.4%) had experienced a traumatic or stressful event prior to the onset of their gender dysphoria. Open text descriptions of trauma were categorized as “family” (including parental divorce, death of a parent, mental disorder in a sibling or parent), “sex or gender related” (such as rape, attempted rape, sexual harassment, abusive dating relationship, break-up), “social” (such as bullying, social isolation), “moving” (family relocation or change of schools); “psychiatric” (such as psychiatric hospitalization), and medical (such as serious illness or medical hospitalization). Almost half (45.0%) of AYAs were engaging in non-suicidal self-injury (NSSI) behavior before the onset of GD. Coping styles for these AYAs included having a poor or extremely poor ability to handle negative emotions productively (58.0%) and being overwhelmed by strong emotions and trying to avoid (or go to great lengths to avoid) experiencing them (61.4%) (Table 4). The majority of respondents (69.4%) answered that their child had social anxiety during adolescence; 44.3% that their child had difficulty interacting with their peers, and 43.1% that their child had a history of being isolated (not associating with their peers outside of school activities).

Table 4. AYA baseline comorbidities and vulnerabilities predating the onset of gender dysphoria.
https://doi.org/10.1371/journal.pone.0202330.t004
Announcing a transgender-identification

At the time the AYA announced they were transgender-identified ("came out"), most were living at home with one or both parents (88.3%) and a small number were living at college (6.2%). The average age of announcement of a transgender-identification was 15.2 years of age (range 10–21) (Table 5). Most of the parents (80.9%) answered affirmatively that their child’s announcement of being transgender came “out of the blue without significant prior evidence of gender dysphoria.” Respondents were asked to pinpoint a time when their child seemed not at all gender dysphoric and to estimate the length of time between that point and their child’s announcement of a transgender-identity. Almost a third of respondents (32.4%) noted that their child did not seem gender dysphoric when they made their announcement and 26.0% said the length of time from not seeming gender dysphoric to announcing a transgender identity was between less than a week to three months. The most striking examples of “not seeming at all gender dysphoric” prior to making the announcement included a daughter who loved summers and seemed to love how she looked in a bikini, another daughter who happily wore bikinis and makeup, and another daughter who previously said, “I love my body.”

The majority of respondents (69.2%) believed that their child was using language that they found online when they “came out.” A total of 130 participants provided optional open text responses to this question, and responses fell into the following categories: why they thought the child was using language they found online (51); description of what the child said but didn’t provide a reason that they suspected the child was using language they found online (61); something else about the conversation (8) or the child (7) and don’t know (3). Of the 51 responses describing reasons why respondents thought their child was reproducing language they found online, the top two reasons were that it didn’t sound like their child’s voice (19 respondents) and that the parent later looked online and recognized the same words and phrases that their child used when they announced a transgender identity (14 respondents). The observation that it didn’t sound like their child’s voice was also expressed as “sounding scripted,” like their child was “reading from a script,” “wooden,” “like a form letter,” and that it didn’t sound like their child’s words. Parents described finding the words their child said to them “verbatim,” “word for word,” “practically copy and paste,” and “identical” in online and other sources. The following quotes capture these top two observations. One parent said, “It seemed different from the way she usually talked—I remember thinking it was like hearing someone who had memorized a lot of definitions for a vocabulary test.” Another respondent said, “The email [my sent to me] read like all of the narratives posted online almost word for word.”

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Table 5. Announcing a transgender-identification.
https://doi.org/10.1371/journal.pone.0202330.t005

The following case summaries were selected to illustrate peer, trauma, and psychiatric contexts that might indicate more complicated clinical pictures.

- A 12-year-old natal female was bullied specifically for going through early puberty and the responding parent wrote “as a result she said she felt fat and hated her breasts.” She learned online that hating your breasts is a sign of being transgender. She edited her diary (by crossing out existing text and writing in new text) to make it appear that she has always felt that she is transgender.

- A 14-year-old natal female and three of her natal female friends were taking group lessons together with a very popular coach. The coach came out as transgender, and, within one year, all four students announced they were also transgender.
A natal female was traumatized by a rape when she was 16 years of age. Before the rape, she was described as a happy girl; after the rape, she became withdrawn and scared. Several months after the rape, she announced that she was transgender and told her parents that she needed to transition.

A 21-year-old natal male who had been academically successful at a prestigious university seemed depressed for about six months. Since concluding that he was transgender, he went on to have a marked decline in his social functioning and has become increasingly angry and hostile to his family. He refuses to move out or look for a job. His entire family, including several members who are very supportive of the transgender community, believe that he is "suffering from a mental disorder with nothing to do with gender."

A 14-year-old natal female and three of her natal female friends are part of a larger friend group that spends much of their time talking about gender and sexuality. The three natal female friends all announced they were trans boys and chose similar masculine names. After spending time with these three friends, the 14-year-old natal female announced that she was also a trans boy.

The majority (76.5%) of the surveyed parents felt that their child was incorrect in their belief of being transgender (Table 5). More than a third (33.7%) of the AYAs asked for medical and/or surgical transition at the same time that they announced they were transgender-identified. Two thirds (67.2%) of the AYAs told their parent that they wanted to take cross-sex hormones; 58.7% that they wanted to see a gender therapist/gender clinic; and 53.4% that they wanted surgery for transition. Almost a third (31.2%) of AYAs brought up the issue of suicides in transgender teens as a reason that their parent should agree to treatment. More than half of the AYAs (55.9%) had very high expectations that transitioning would solve their problems in social, academic, occupational or mental health areas. While 43.9% of AYAs were willing to work on basic mental health before seeking gender treatments, a sizable minority (28.1%) were not willing to work on their basic mental health before seeking gender treatment. At least two parents relayed that their child discontinued psychiatric care and medications for pre-existing mental health conditions once they identified as transgender. One parent, in response to the question about if their child had very high expectations that transitioning would solve their problems elaborated, "Very much so. She stopped seeing the psychologist, stopped taking medication." This was her cure, in her opinion."

Friend-group exposure

The adolescent and young adult children were, on average, 14.4 years old when their first friend became transgender-identified (Table 6). Within friendship groups, the average number of individuals who became transgender-identified was 3.5 per group. In 36.8% of the friend groups described, the majority of individuals in the group became transgender-identified. The order that the focal AYA "came out" compared to the rest of their friendship group was calculated from the 119 participants who provided the number of friends coming out both before and after their child and 74.8% of the AYAs were first, second or third of their group. Parents described intense group dynamics where friend groups praised and supported people who were transgender-identified and ridiculed and malign non-transgender people. Where popularity status and activities were known, 60.7% of the AYAs experienced an increased popularity within their friend group when they announced a transgender-identification and 60.0% of the friend groups were known to mock people who were not transgender or LGBTQIA (lesbian, gay, bisexual, transgender, intersex, or asexual).

Table 6. Friend group exposure.
https://doi.org/10.1371/journal.pone.0202330.t006

For the question about popularity changes when the child came out as having a transgender-identification, 79 participants provided optional open text responses which were categorized as: descriptions of the responses the child received (39); descriptions of the friends (14); description that the child did not "come out" to friends (8); not sure (9); speculation on how the child felt from the response (4), other (5). Of the 39 descriptions of responses, 19 of these responses referred to positive benefits the child received after coming out including positive attention, compliments, increased status, increased popularity, increased numbers of online followers, and improved protection from ongoing bullying. The following are quotes from parents about the perceived benefits of transgender-identification afforded to their child. One respondent said, "Great increase in popularity among the student body at large. Being trans is a gold star in the eyes of other teens." Another respondent explained, "not so much popularity increasing as 'status'. Also she became untouchable in terms of bullying in school as teachers who ignored homophobic bullying ... are now all at pains to be on the heels of any trans bullying." Seven respondents described a mixed response where the child's popularity increased with some friends and decreased with others. Seven respondents described a neutral response such as "All of the friends seemed extremely accepting." Two described a temporary increase in their child's popularity: "There was an immediate rush of support when he came out. Those same friends have dwindled to nothing as he rarely speaks to any of them now." Another described the loss of friends. And two parents described that "coming out" prevented the loss of friends explained by one respondent as "not to be trans once would not have been included in his group."

Several AYAs expressed significant concern about the potential repercussions from their friend group when they concluded that they were not transgender after all. There were two unrelated cases with similar trajectories where several AYAs spent some significant time in a different setting, away from their usual friend group, without access to the internet. Parents described that these AYAs made new friendships, became romantically involved with another person, and during their time away concluded that they were not
transgender. In both cases, the adolescents, rather than face their school friends, asked to move and transfer to different high schools. One parent said that their child, "... didn't face the stigma of going back to school and being branded as a fake or phony... Or worse, a traitor or some kind of betrayer...[and] asked us if we could move." In the other case, the parent relayed that their child thought none of the original friends would understand and expressed a strong desire to "...get out of the culture that if you are cis, then you are bad or oppressive or clueless." Both families were able to relocate and both respondents reported that their teens have thrived in their new environments and new schools. One respondent described that their child expressed relief that medical transition was never started and felt there would have been pressure to move forward had the family not moved away from the peer group.

Qualitative analysis
The open-ended responses from the question about whether the AYAs and friends mocked, teased, or made fun of individuals who weren't transgender or LGBTIA was selected for additional qualitative analysis. Seven major themes were identified from the comments provided by participants and are described, with representative supporting quotes.

**Theme: groups targeted.** The groups targeted for mocking by the friend groups are often heterosexual (straight) people and non-transgender people (called "cis" or "cisgender"). Sometimes animosity was also directed towards males, white people, gay and lesbian (non-transgender) people, aromatic and asexual people, and "terfs." One participant explained, "They are constantly putting down straight, white people for being privileged, dumb and boring." Another participant elaborated, "In general, cis-gendered people are considered evil and unsupportive, regardless of their actual views on the topic. To be heterosexual, comfortable with the gender you were assigned at birth and non-minority places you in the 'most evil' of categories with this group of friends. Statement of opinions by the evil cis-gendered population are considered phobic and discriminatory and are generally discounted as unenlightened."

**Theme: individuals targeted.** In addition to targeting specific groups of people for mocking, the AYAs and their friend groups also directed mocking towards individuals in the AYAs' lives such as parents, grandparents, siblings, peers, allies, and teachers. The following quotes describe individuals targeted. One participant said, "They call kids who are not LGBT dumb and cis. And the mocking has been aimed at my transgender-identified child's [sibling]." Another parent said, "They definitely made fun of parents and teachers who did not agree with them." And a third participant said, "...they were asked to leave [a school-based LGBT] club because they were not queer enough [as straight and bisexual allies]. One of them was then bullied, harassed and denounced online."

**Theme: behaviors occurred both in person and in online settings.** Parents observed the behaviors both in-person and in online settings, and specifically mentioned seeing posts and conversations on Twitter, Tumblr, Facebook, and Instagram. On participant said, "They speak with derision about how cis-gendered people do not understand them and are so close-minded." Another participant said, "I hear them disparaging heterosexuality, marriage and nuclear families." Another participant said, "On my daughter's Tumblr blog, she has liked or favorited or re-posted disparaging comments about those who aren't transgender or seem to misunderstand the trans-gender identity." And another parent reported, "Her real life friends don't [mock non-LGBT] people but online they are always swapping jokes and comments about cisgender and about transphobia."

**Theme: examples of behaviors.** Participants gave many examples of the observed behaviors that were mocking towards non-transgender people and non-LGBT one person. One participant said, "My daughter called me a 'breeder' and says things in a mocking 'straight person voice'. Her friends egg her on when she does this." Another parent offered, "If they aren't mocking 'cis' people, they are playing pronoun police and mocking people who can't get the pronouns correct." Another participant said, "New vocabulary includes 'cis-stupid' and 'cis-stupidity."

**Theme: emphasizing victimhood.** Participants described that their children and friend group seemed to focus on feeling as though they were victims. One participant described, "They seem to wear any problems they may have, real or perceived like badges of honor...I feel like they want to believe they are oppressed & have really 'been through life', when they have little life experience." Another participant said, "...there is a lot of feeling like a victim [and being] part of a victimized club." Another parent said "But all talk is very 'victim' centered." And finally, another said, "They passionately decry 'Straight Privilege' and 'White Male Privilege'—while emphasizing their own 'Victimhood'."

**Theme: consequences of behaviors.** A few participants described that because of their child's behavior, there were consequences, including making it difficult for one child to return to her school and the following description from another parent, "Most relatives have blocked her on [social media] over constant jokes regarding cis and straight people."

**Theme: fueling the behaviors.** In some cases, parents describe a synergistic effect of kids encouraging other kids to persist in the behavior as described in a previous quote, "Her friends egg her on when she does this" as well as the following, "Lots of discussion revolving around how their teachers 'discriminate' or are 'mean' to them based on their declared LGBTIQA identity, and they get each other riled up convincing each other of their persecution by these perceived wrongs ... privately they mock our intolerance, and in person act upon these false beliefs by treating us as people out to get them..."
Parents identified the sources they thought were most influential for their child becoming gender dysphoric. The most frequently answered influences were: YouTube transition videos (63.6%); Tumblr (51.7%); a group of friends they know in person (44.5%); a community group of people that they met online (42.2%); a person they know in-person (not online) 41.7%. In contrast to the majority of responses, two participants commented that they didn’t think the sources influenced their child to become gender dysphoric, rather they gave their child a name for their feelings or gave the child confidence to come out. The following quotes illustrate the dominant quantitative findings. One parent wrote, “We believe the biggest influence was the online transition blog on YouTube videos. He feels he was highly influenced by the “if you are even questioning your gender-you are probably transgender” philosophy... In the ‘real world’ her friends, other trans peers, and newfound popularity were additional areas of reinforcement.” Another respondent described the online influence as part of a different question, “I believe my child experienced what many kids experience on the cusp of puberty—uncomfortableness—but there was an online world at the ready to tell her that those very normal feelings meant she’s in the wrong body.”

Mental well-being, mental health, and behaviors

The trajectories of the AYAs were not consistent with the narrative of discovering one’s authentic self and then thriving. Specifically, parents reported that, after “coming out,” their children exhibited a worsening of their mental well-being. Additionally, parents noted worsening of the parent-child relationship and observed that their children had narrowed their interests (Table 8). Although small numbers of AYAs had improvement in mental well-being (12.6%), parent-child relationship (7.4%), grades/academic performance (6.4%), and had broadened their interests and hobbies (5.1%); the most common outcomes were worsened mental well-being (47.2%); worsened parent child relationship (57.3%); unchanged or mixed grades/academic performance (59.1%); and a narrowed range of interests and hobbies (58.1%). One parent describing her child’s trajectory offered, “After announcing she was transgender, my daughter’s depression increased significantly. She became more withdrawn. She stopped participating in activities which she previously enjoyed, stopped participating in family activities, and significantly decreased her interaction with friends. Her symptoms became so severe that she was placed on medication by her physician.” Table 9 describes cumulative rates of mental illness and neurodevelopmental disability at the time of survey.

Table 7. Internet/social media exposures.
https://doi.org/10.1371/journal.pone.0202330.t007

<table>
<thead>
<tr>
<th>Internet/social media exposures</th>
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<tbody>
<tr>
<td>YouTube transition videos</td>
<td>63.6</td>
<td></td>
</tr>
<tr>
<td>Tumblr</td>
<td>51.7</td>
<td></td>
</tr>
<tr>
<td>A group of friends they know in person</td>
<td>44.5</td>
<td></td>
</tr>
<tr>
<td>A community group of people that they met online</td>
<td>42.2</td>
<td></td>
</tr>
<tr>
<td>A person they know in-person (not online)</td>
<td>41.7</td>
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Table 8. Outcomes and behaviors.
https://doi.org/10.1371/journal.pone.0202330.t008

<table>
<thead>
<tr>
<th>Outcomes and behaviors</th>
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<td>Parent-child relationship</td>
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<tr>
<td>Grades/academic performance</td>
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<tr>
<td>Interests and hobbies</td>
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<tr>
<td>NAR</td>
<td>58.1</td>
<td></td>
</tr>
<tr>
<td>Mental illness</td>
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</tr>
<tr>
<td>Neurodevelopmental disability</td>
<td>58.1</td>
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Table 9. AYA Cumulative mental disorder and neurodevelopmental disability diagnoses.

http://journals.plos.org/plosone/article?id=10.1371/journal.pone.020230
A total of 63.8% of the parents have been called “transphobic” or “bigoted” by their children for one or more reasons, the most common being for: disagreeing with the child about the child’s self-assessment of being transgender (51.2%); recommending that the child take more time to figure out if their feelings of gender dysphoria persist or go away (44.6%); expressing concerns for the child’s future if they take hormones and/or have surgery (40.4%); calling their child by the pronouns they used to use (37.9%); telling the child they thought that hormones or surgery would not help them (37.5%); recommending that their child work on other mental health issues first to determine if they are the cause of the dysphoria (33.3%); calling the child by their birth name (33.3%); or recommending a comprehensive mental health evaluation before starting hormones and/or surgery (20.8%) (Table 10). There were eight cases of estrangement. Estrangement was child-initiated in six cases where the child ran away, moved out, or otherwise refused contact with parent. There were two cases where the estrangement was initiated by the parent because the AYA’s outbursts were affecting younger siblings or there was a threat of violence made by the AYA to the parent.

Table 10. Additional behaviors.  
https://doi.org/10.1371/journal.pone.0202330.t010

AYAs are reported to have exhibited one or more of the following behaviors: expressed distrust of information about gender dysphoria and transgenderism coming from mainstream doctors and psychologists (51.8%); tried to isolate themselves from their family (49.4%); expressed that they only trust information about gender dysphoria and transgenderism that comes from transgender websites and/or transgender people and sources (46.6%); lost interest in activities where participants aren’t predominantly transgender or LGBTA (32.3%); stopped spending time with friends who were not transgender (25.1%); expressed distrust of people who were not transgender (22.7%) (Table 10). Many AYAs have also withdrawn from their family (45.0%); told other people or posted on social media that their parent is “transphobic,” “abusive,” or “toxic” because the parent does not agree with child’s self-assessment of being transgender (43.0%); refused to speak to their parent (28.5%), defended the practice of lying to or withholding information from therapists or doctors in order to obtain hormones for transition more quickly (16.5%); tried to run away (6.8%). The behaviors and outcomes listed above were considered significant changes from the child’s baseline behaviors for 71.4% of respondents checking any of the items.

There was a subset of eight cases where parents described watching their child have declining mental well-being as they became gender dysphoric and transgender-identified and then had improving mental well-being as they dropped or backed away from a transgender-identification. One parent described a marked change in her daughter when she was out of school temporarily. [Her] routine was disrupted. She spent all day on the internet, and lost her many school friends—her only friends were on-line and members of the trans community. In three months, my daughter announced she is trans, gender dysphoric, wants binders and top surgery, testosterone shots...she started self-harming. Now back at school...she tweeted that she’s so young, isn’t sure if she is trans, no longer wants to be referred to by the male name she had chosen... Since she has started back at school and is being exposed to a wide variety of people she is WAY happier.” Another parent described, “My daughter’s insight has improved considerably over the last few years, and she has also outgrown the belief that she is transgender. My daughter actually seemed to be looking for a reason for her depression which is now being successfully treated...My daughter is MUCH happier now that she is being treated for her genuine issues. Coming out as trans made her much worse for a while.”

There was a subset of 30 cases where the AYAs’ transgender-identification occurred in the context of a decline in their ability to function (such as dropping out of high school or college, needing a leave of absence from high school or college, and/or being unable to obtain or hold a job), which parents reported as a significant change from their child’s baseline behavior. The declines were substantial as 43.5% of these AYAs had been identified as academically gifted students (some described as top of their class in high school, earning outstanding grades at prestigious universities) before they began to fail their classes, drop out of high school or college, and become unable to hold a job. In most of these cases (76.7%), there was one or more psychiatric diagnosis made at the same time or within the year (60.0%) or within two years (16.7%) of the AYA’s transgender-identification. Of the 23 individuals who had a psychiatric diagnosis made within two years of assuming a transgender-identification, 91.3% (21/23) were diagnosed with depression; 73.9% (17/23) with anxiety; 26.0% (6/23) with bipolar disorder; 17.4% (4/23) with borderline personality disorder; 8.7% (2/23) with psychosis/psychotic episode; and 8.7% (2/23) with an eating disorder.

Clinical encounters

Parents were asked if their child had seen a gender therapist, gone to a gender clinic, or seen a physician for the purpose of beginning transition and 92 respondents (36.2%) answered in the affirmative (Table 11). Many of the respondents clarified that their child had seen a clinician regarding their gender dysphoria for evaluation only. Although participants were not asked directly what kind of provider their child saw, specialties that were mentioned in answers included: general psychologists, pediatricians, family doctors, social workers, gender therapists, and endocrinologists. For parents who knew the content of their child’s evaluation, 71.6% reported that the clinician did not explore issues of mental health, previous trauma, or any alternative causes of gender
The table below illustrates interactions with clinicians. The data suggest that parents were often reluctant to discuss their children's gender dysphoria, and that there was a lack of communication between the patient and their primary care physician. The table also highlights the challenges faced by parents in seeking appropriate medical care for their children. The data indicate that there is a need for improved communication and support for parents and children in these situations.

Table 11: Interactions with Clinicians
https://doi.org/10.1371/journal.pone.0202330.1011

One participant described, "For the most part, I was extremely frustrated with providers NOT acknowledging the mental disorder, anxiety, depression, etc before recommending hormone replacement therapy. And two participants described how the clinician treating their child's gender dysphoria refused to speak with the patient's primary care physician. One participant said, "When we phoned the clinic, the doctor was hostile to us, told us to mind our own business. Our family doctor tried to reach our son's new doctor, but the trans doctor refused to speak with her." Another respondent shared "The pediatrician/gender specialist did not return calls or emails from the primary care physician who requested to talk with her about my son’s medical history before he was treated...she disregarded all historical information provided by the family and primary care physician...did not verify any information provided by my...son at his first visit even after being provided with multiple other historical sources which differed significantly from his story."

When asked about whether their child relayed their history completely and accurately to clinicians or whether they misrepresented or omitted parts of their history, of those who knew the content of their child's visit, 84.9% of the parent respondents were reasonably sure or positive that their child had misrepresented or omitted parts of their history. Twenty-eight participants provided reasonable open text responses to this question and the responses were categorized into: describing how the parent knew that the child misrepresented their history (5); the content of what the child misrepresented (6 misrepresented in general, 4 mirroring to the clinician for a total of 10 examples); don't know/not sure (4); expressing certainty (1); and not relevant (8). For the five participants describing how they knew, the reasons included: being present when it happened, reading the report from the gender specialist, being told by their child that the child had misrepresented the truth, and being informed by the child's psychiatrist. One respondent shared, "I have read the report from the gender specialist and it omits all the relevant context painting an almost unrecognizable picture of my son." A second respondent simply responded, "I was present." Another respondent relayed about their (natal male) child, "My daughter told me and her mother that the first therapist she saw asked her stereotypical questions...She was afraid that if she didn't describe herself as a 'typical girl' she would not be believed." And finally, one respondent wrote, "He has said now that he did [misperse his history] and used key words he was advised to say." Ten participants provided 13 examples of the content of misrepresentations and of these, 6 examples could have been easily verified to be false (claiming to be under the care of a psychiatrist, claiming to be on medication to treat a psychiatric condition, how one was doing academically, and claiming a childhood history of having playmates of one sex when the opposite was observed, and claiming strong childhood preferences for specific toys and clothing that is the opposite of what multiple individuals observed). Three of the content examples would have been challenging to verify as false including: how one was feeling as a child, how one was feeling when a picture was taken, and whether one was from an abusive home. And four of the content examples did not provide enough information to determine if they would be easy or challenging to verify as false, such as "My child distorts her history and our family life on a regular basis," and "He has created an entire narrative that just isn't true."

In addition to the previously mentioned case where the child literally rewrote her history by editing her diary, there were seven respondents who conveyed a process where the child was constantly rewriting their personal history to make it consistent with the idea that they always were transgender and/or had created a childhood history that was not what others had observed. It is unclear whether this process was deliberate or if the individuals were unaware of their actions. The following are quotes describing this phenomenon. One parent said, "...she is actively rewriting her personal history to support the idea that she was always trans." Another respondent added, "...my daughter denies events I recall from her childhood and puberty that contradicts her narrative of "always knowing she was a boy"." Another respondent offered, "He is rewriting his personal history to suit his new narrative." And a fourth respondent described, "Our son has completely made up his childhood to include only girl friends and dressing up in girls clothes and playing with dolls, etc. This is not the same childhood we have seen as parents."

Qualitative analysis

The open-ended comments from the question about whether the clinician explored mental health, trauma or alternative causes of gender dysphoria before proceeding were selected for qualitative analysis. Nine major themes emerged from the data. Each theme is described in the following paragraphs with supporting quotes from participants.

Theme: Failure to explore mental health, trauma or alternative causes of GD. Parents described that clinicians failed to explore their child's mental health, trauma, or any alternative causes for the child's gender dysphoria. This failure to explore mental health and trauma occurred even when patients had a history of mental health disorder or trauma, were currently being treated for a
mental health disorder, or were currently experiencing symptoms. One participant said, “Nothing other than gender dysphoria was currently affecting my daughter.” Another participant said, “My daughter said the therapist was preparing to support transgendersing and did not explore the depression and anxiety or previous trauma.”

**Theme: Insufficient evaluation.** Another theme was insufficient evaluation where parents described evaluations that were too limited or too superficial to explore mental health, trauma or alternative causes of gender dysphoria. The following are three quotes by three different parents describing insufficient evaluations. One parent said, “The exploration was egregiously insufficient, very shallow, no effort to ask questions, engage in critical thinking about coexisting anxiety, or put on the brakes or even slow down.” Another parent stated, “When we tried to give our son’s trans doctor a medical history of our son, she refused to accept it. She said the half hour diagnosis in her office with him was sufficient, as she considers herself an expert in the field. And a third parent wrote, “We were STUNNED by the lack of interest shown by our therapist at the time of initial visit. [One] visit. The idea is, ‘if they say they were born in the wrong body, they are. To question this will only hurt her and prolong her suffering.’ [Our] daughter has had trauma in [the] past. [She] never was asked about it. [The] therapist did not ask parents a single question about our daughter.”

**Theme: unwillingness or disinterest in exploring mental health, trauma or alternative causes of GD.** Parents described that clinicians did not seem interested or willing to explore alternative causes. One parent described, “Her current therapist seems to accept her self diagnosis of gender dysphoria and follows what she says without seeming too much interested in exploring the sexual trauma in her past.” Another parent wrote, “The Asperger psychiatrist did not seem to care whether our daughter’s gender dysphoria stemmed from Asperger’s. If our daughter wanted to be male, then that was enough.” And a third parent said, “The therapist did ask about those issues but seemed to want to accept the idea wholeheartedly that my daughter was transgender first and foremost, all other factors aside.”

**Theme: mental health was explored.** A few parents had the experience where the clinician either made an appropriate referral for further evaluation or the issues had been addressed previously. One parent said, “[the] previous mental health issues were already explored by other therapists [my] child was in therapy and medicated before coming out as transgender.”

**Theme: failure to communicate with patients’ medical providers.** Several parents described clinicians who were unwilling to communicate with primary care physicians and mental health professionals even those professionals who were currently treating the patient. One parent relayed, “She did not review the extensive psychiatric records that were available in a shared EMR [electronic medical record] and she did not consult with his outpatient psychiatrist prior to or after starting cross-sex hormonal therapy.” Another parent said, “My child had been seen for mental health issues for several years before presenting this new identity, but the endocrinologist did not consult the mental health professionals for their opinions before offering hormones.”

**Theme: misrepresentation of Information by the patient.** Several parents described how their child misrepresented their history to the clinician, thus, limiting the clinician’s ability to adequately explore mental health, trauma and alternative causes. One participant wrote, “At [the] first visit, [my] daughter’s dialogue was well-rehearsed, fabricated stories about her life told to get [the] outcome she desired. She parroted people from the internet.” Another parent reported, “My son concealed the trauma and mental health issues that he and the family had experienced.” And a third parent said, “I overheard my son boasting on the phone to his older brother that the doc swallowed everything I said hook, line and sinker. Easiest thing I ever did.”

**Theme: transition steps were pushed by the clinician.** Some parents described clinicians who seemed to push the process of transition before the patient asked for it. One parent described that the doctor gave her daughter a prescription that she didn’t ask for. “The family was notified who gave her [her] prescription Rx [prescriber] did not ask many questions (she was surprised by this), nor did he await her assessment by a licensed psychiatrist before giving her this Rx. Nor did she ask him for this Rx.” Another parent reported that she and her child were at the endocrinologist’s office only to ask questions, and described, “...[he] didn’t listen to a word we were saying. He was too eager to get us set up with a ‘gender therapist’ to get the legal form he needed to start hormones, all while making sure we set up our next appointment within 6 months to start the hormones...”

**Theme: parent views were discounted or ignored.** Parents describe that the clinicians did not take their concerns seriously. One parent described, “I have to say I don’t know, but it is hard to believe that they adequately examined the history of bullying and being suffering different that would lend a person like my daughter’s desire to risk everything for identifying with a group. I know that in the few contacts I had with the providers, my concerns were discounted.” Another parent, “All of our emails went unanswered and were ignored. We are left out of everything because of our constant questioning of this being right for our daughter [because of her] trauma and current depression, anxiety and self-esteem problems.”

**Theme: parent had concerns about the clinicians’ competence, professionalism or experience.** Parents expressed doubts about the clinicians regarding their experience, competence or professionalism. One parent said, “The clinic told me they explored these issues. I asked the risk manager at [redacted] if they considered a personality disorder. ‘Oh, no,’ she laughed. ‘That’s only with the older patients, not the teenagers.’ I’m deeply suspicious of their competence.” Another parent described, “What does concern me is that the people she talked to seemed to have no sense of professional duties, but only a mission to promote a specific social ideology.”

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**Steps towards transition and current identification status**

This section reports on the duration of AYA transgender-identification (time from the AYA’s announcement of a transgender identity until the time the parent completed the survey) that covers, on average, 15.0 months (range 0.1–120 months) with a median of 11 months (Table 12). The steps taken towards transition during this timeframe are listed in Table 12. At the end of the timeframe, 83.2% of the AYAs were still transgender-identified, 5.5% were not still transgender-identified (desisted), 2.7% seemed to be backing away from transgender-identification, and 8.6% of the parents did not know if their child was still identifying as transgender. Descriptions of backing away or moving from transgender-identified to not transgender-identified include the following. One parent observed, “She identified as trans for six months... Now back at school, she is thinking maybe she’s not trans.” Another parent offered, “My daughter [identified] as trans from ages 13–16. She gradually desisted as she developed more insight into who she is.” One parent described that after one year of identifying as transgender, “basically, she changed her mind once she stopped spending time with that particular group of friends.” The duration of transgender-identification of the AYAs who were still transgender-identified at the time of the survey was compared to the duration of those who were no longer transgender-identified and those who seemed to be backing away from a transgender-identification (combined by t-test. The difference between these groups was statistically significant (p = .025), with a t-value of -1.95 showing that those who were no longer transgender-identified and backing away had a longer duration of identification (mean = 24.1 months) and those who were still transgender-identified had a shorter mean duration (mean = 14.4 months).
To explore the differences between the AYAs who had exposure to social influence (friend group, internet/social media, or both) and AYAs who did not have a clear exposure to social influence (neither and don’t know), a series of chi-squared calculations were performed for selected variables. (See Table 13.) Statistically significant differences were revealed for AYAs with exposure to social influences having worse outcomes for mental well-being and parent-child relationships, and greater numbers exhibiting distrust, isolating and anti-social behaviors including: narrowed range of interests and hobbies, expressing that they only trusted information from transgender sources, trying to isolate themselves from their family, losing interest in activities that weren’t predominantly with transgender or LGBT+ participants, and telling people or posting on social media that their parent is “transphobic,” “abusive,” or “toxic” because the parent doesn’t agree with the child’s assessment of being transgender. Although the differences in additional isolating and anti-social behaviors did not reach statistical significance, these behaviors trended towards higher rates in the AYAs who were exposed to social influence and may have not reached significant levels due to small numbers. No significant difference for age of AYA (at announcement or at time of survey completion) was detected between groups by a one-way ANOVA.

Table 13. chi-squared comparisons for exposure to social influence (S) vs not exposure to social influence (NSI).
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Discussion
This research describes parental reports about a sample of AYAs who would not have met diagnostic criteria for gender dysphoria during their childhood but developed gender dysphoria during adolescence or young adulthood. The strongest support for considering that the gender dysphoria was new in adolescence or young adulthood is the parental answers for DSM 5 criteria for childhood gender dysphoria. Not only would none of the population have met threshold criteria, the vast majority had zero indicators. Although one might argue that three of the indicators could plausibly be missed by a parent (A1, A7, and A8 if the child had not expressed this verbally), five of the indicators (A2-6) are readily observable behaviors and preferences that would be difficult for a parent to miss. Six indicators (including A1) are required for a threshold diagnosis. The nonexistent and low numbers of readily observable indicators reported in the majority of this population does not support a scenario in which gender dysphoria was always present but was only recently disclosed to the parents.

Before the onset of their gender dysphoria, many of the AYAs had been diagnosed with at least one mental health disorder or neurodevelopmental disability and many had experienced a traumatic or stressful event. Experiencing a sex or gender related trauma was not uncommon, nor was experiencing a family stressor (such as parental divorce, death of a parent, or a mental health disorder in a sibling or parent). Additionally, nearly half had been engaging in self-harm prior to the onset of their gender dysphoria. In other words, many of the AYAs and their families had been navigating multiple challenges and stressors before gender dysphoria and transgender-identification became part of their lives. This context could possibly contribute to friction between parent and child and these complex, overlapping difficulties as well as experiences of same-sex attraction may also be influential in the development
of a transgender identification for some of these AYAs. Care should be taken not to overstate or understate the context of pre-existing diagnoses or trauma in this population as they were absent in approximately one third and present in approximately two thirds of the sample.

This research sample of AYAs also differs from the general population in that it is predominantly natal female, white, and has an over-representation of individuals who are academically gifted, non-heterosexual, and are offspring of parents with high educational attainment [41–43]. The sex ratio favoring natal females is consistent with recent changes in the population of individuals seeking care for gender dysphoria. Gender clinics have reported substantial increases in referrals for adolescents with a change in sex ratio of patients moving from predominantly natal males seeking care for gender dysphoria to predominantly natal females [19, 44–48]. Although a decrease in stigma for transgender individuals might explain some of the rise in the numbers of adolescents presenting for care, it would not directly explain the inversion of the sex ratio. It is plausible that rapid-onset of gender dysphoria may have some similarities to anorexia nervosa and the characteristics that make female adolescents more susceptible than male adolescents to anorexia nervosa may be the same characteristics that make natal females more susceptible than natal males to rapid-onset gender dysphoria. The unexpectedly high rate of academically gifted AYAs may be related to the high educational attainment of the parents and may be a reflection of parents who are online, able to complete the surveys and are able to quickly and easily access current research and case examples about gender dysphoria and transition. There may be other unique variables that render academically gifted AYAs susceptible to rapid-onset gender dysphoria. The higher than expected rate of non-heterosexual orientations of the AYAs (prior to announcement of a transgender identity) may suggest that the desire to be the opposite sex could stem from experiencing homophobia as a recent study showed that being the recipient of homophobic name calling from one’s peers was associated with a change in gender identity for adolescents [47].

The potential relationship of experienced homophobia and the development of ROGD deserves further study.

This population is distinctively different than what is described in previous research about gender dysphoria because of the distribution of new cases occurring in friendship groups, the preponderance of adolescent (natal) females, the absence of childhood gender dysphoria, and the suddenness of onset. The gender dysphoria and transgender-identification of rapid-onset gender dysphoria may be temporary. The study’s findings on duration of transgender-identification suggests that a longer observation period might reveal greater rates of desistance and is consistent with anecdotal reports of adolescents who desisted from rapid-onset gender dysphoria approximately 9 to 36 months after presentation. Although it is still unknown whether transitional treatment can facilitate changes in gender dysphoria of attempted or completed suicides [48], this study documents AYAs using a suicide narrative to manipulate parents and doctors into supporting and providing transition services. Despite the possibility that the AYAs are using a suicide narrative to manipulate others, it is critical that any suicide threat, ideation or concern is taken seriously and the individual should be evaluated immediately by a mental health professional.

The majority of parents were reasonably sure or certain that their child misrepresented or omitted key parts of their history to their therapists and physicians. In some cases, the misrepresentation of one’s history may simply be a deliberate act by a person who is convinced that transition is the only way that they will feel better and who may have been coached that lying is the only way to get what they think they need. For others, the misrepresentation may not be a conscious act. The creation of an alternate version of one’s childhood that conforms to a story of always knowing one was transgender and that is in sharp contrast to the childhood that was observed by third parties raises the question of whether there has been the creation of false childhood memories as part of, or outside of, the therapy process. Respondent accounts of clinicians who ignored or disregarded information (such as mental health symptoms and diagnoses, medical and trauma histories) that did not support the conclusion that the patient was transgender, suggests the possibility of motivated reasoning and confirmatory bias on the part of clinicians. In the 1990s, the beliefs and practices of many mental health professionals may have contributed to their patients’ creation of false childhood memories consistent with a child sexual abuse narrative and research since then has shown that false childhood memories of mundane events can be implanted in laboratory settings [49–51]. It may be worthwhile to explore if, in today’s culture, there may be beliefs and practices of some mental health professionals that are contributing to their patients’ creation of false childhood memories consistent with an “always knew/ways were transgender” narrative.

Emerging hypotheses

Hypothesis 1: Social contagion is a key determinant of rapid-onset gender dysphoria (ROGD).

It is unlikely that friends and the internet can make people transgender. However, it is plausible that the following can be initiated, magnified, spread, and maintained via the mechanisms of social and peer contagion: (1) the belief that non-specific symptoms (including the symptoms associated with trauma, symptoms of psychiatric problems, and symptoms that are part of normal puberty) should be perceived as gender dysphoria and their presence as proof of being transgender; (2) the belief that the only path to happiness is transition; and (3) the belief that anyone who disagrees with the self-assessment of being transgender or the plan for transition is transphobic, abusive, and should be cut out of one’s life. The spread of these beliefs, in turn, may promote ROGD by misinterpreting symptoms, incorrectly believing themselves to be transgender and in need of transition, and then inappropriately rejecting all information that is contrary to these beliefs. In other words, “gender dysphoria” may be used as a catch-all explanation for any kind of distress, psychological pain, and discomfort that an AYA is feeling while transition is being promoted as a cure-all solution.

One of the most compelling findings supporting the potential role of social and peer contagion in the development of a rapid onset of gender dysphoria is the cluster outbreaks of transgender-identification occurring in friendship groups. The expected prevalence of gender dysphoria among adolescent individuals is 0.7% [4]. Yet, more than a third of the friendship groups described in this study had 50% or more of the AYAs in the group becoming transgender-identified in a similar time frame, a localized increase to more than 70 times the expected prevalence rate. This is an observation that demands urgent further investigation. One might argue that the high rates of transgender-identified individuals within these friendship groups were secondary only to the process of friend selection; choosing transgender-identified friends deliberately rather than the result of group dynamics and observed coping styles contributing to multiple individuals, in a similar timeframe, starting to interpret their feelings as consistent with being transgender. More research will be needed to finely delineate the timing of friend group formation and the timing and pattern of each new declaration of transgender-identification. Although friend selection may play a role in these high percentages of transgender-identifying members in friend groups, the described pattern of multiple friends (and often the majority of the friends in the friend group) becoming transgender-identified in a similar time frame suggests that there may be more than just friend selection behind these elevated percentages.

There are many insights from our understanding of peer contagion in eating disorders and anorexia that may apply to the potential peer contagion of rapid-onset gender dysphoria. Just as friendship cliques can set the level of preoccupation with one’s body, body image, weight, and techniques for weight loss [23–30], so too may friendship cliques set a level of friendship cliques set a level of preoccupation with one’s body, body image, gender, and the techniques to transition. The descriptions of pro-anorexia subculture group dynamics where the thinnest anorexics are admired while the anorexics who try to recover from anorexia are ridiculed and maligned as outsiders [30–32] resemble the group dynamics in friend groups that validate those who identify as transgender and mock those who do not. And
the pro-eating-disorder websites and online communities providing inspiration for weight loss and sharing tricks to help individuals derive parents and doctors [53–56] may be analogous to the inspirational YouTube transition videos and the shared online advice about manipulating parents and doctors to obtain hormones.

Hypothesis 2: NOGO is a maladaptive coping mechanism for AYA.

For some individuals, the drive to transition may represent an ego-syntonic but maladaptive coping mechanism to avoid feeling strong or negative emotions similar to how the drive to extreme weight loss can serve as an ego-syntonic but maladaptive coping mechanism in anorexia nervosa [52–53]. A maladaptive coping mechanism is a response to a stressor that might relieve the symptoms temporarily but does not address the cause of the problem and may cause additional negative outcomes. Examples of maladaptive coping mechanisms include the use of alcohol, drugs, or self-harm to distract oneself from experiencing painful emotions. One reason that the treatment of anorexia nervosa is so challenging is that the drive for extreme weight loss and weight loss activities can become a maladaptive coping mechanism that is triggered by a stressor. If the patient is not helped by the coping mechanism and does not address the cause of the problem, it could result in additional negative outcomes [54]. In this context, dieting is not felt as distressing to the patient, because it is considered by the patient to be the solution to her problems, and not part of the problems. In other words, the dieting and weight loss activities are ego-syntonic to the patient. However, distress is felt by the patient when external actors (doctors, parents, hospital staff) try to interfere with her weight loss activities thus curtailing her maladaptive coping mechanism.

Findings that may support a maladaptive coping mechanism hypothesis include that the most likely description of AYA ability to use negative emotions productively was poor/extremely poor and the majority of AYAs were described as "overwhelmed by strong emotions and tired/bored at great lengths to avoid experiencing them." Although these are not valid questions, the findings suggest that the majority of AYAs who had transition would solve their problems coupled with the sizable minority who became unwilling to work on their basic mental health issues before seeking treatment support the concept that the drive to transition might be used to avoid dealing with mental health issues and aversive emotions. Additional support for this hypothesis is that the sample of AYAs described in this study are predominantly female, experienced the onset of symptoms during adolescence and contained an overrepresentation of AYAs medically staged with anorexia nervosa than populations of individuals diagnosed with anorexia nervosa as they are predominantly female [55–56]; typically have the onset of symptoms in adolescence [57] and are likely to have high IQ [58–59]. The risk factors, mechanisms and meanings of anorexia nervosa [53, 54, 60] may ultimately prove to be a valuable template to understand the risk factors, mechanisms, and meanings of rapid-onset gender dysphoria.

Transitions as a drive to escape one’s gender, emotions, or difficult realities might also be considered when the drive to transition arises after a sex or gender-related trauma or within the context of significant psychiatric symptoms and decline in ability to function. Although trauma and psychiatric disorders are not specific for the development of gender dysphoria, these experiences may leave a person in psychological pain and in search of a coping mechanism. The first coping mechanism that a vulnerable person adopts may be the result of their environment and which narratives for pain and coping are most prevalent in that environment—in some settings a gender dysphoria/drive to transition may be the dominant paradigm, in some settings a body dysphoric/drive for extreme weight loss is dominant, and in another the use of alcohol and drugs to cope with pain may be dominant. Because maladaptive coping mechanisms do not address the root cause of distress and may cause their own negative consequences, the most likely outcome in this sample, AYAs experiencing a decline in their mental well-being after transgender identification, is consistent with this hypothesis. There was a subset of AYAs who had improvement in their mental well-being as they desisted from their transgender identification which would not be inconsistent with moving from a maladaptive coping mechanism to an adaptive coping mechanism.

If the above hypotheses are correct, rapid onset of gender dysphoria that is socially mediated and/or used as a maladaptive coping mechanism may be harmful to AYAs in the following ways: (1) non-treatment or delayed treatment for trauma and mental health problems that might be the root of (or at least an inherent part of) the AYAs' issues; (2) alienation of the AYAs from their parents and other crucial social support systems; (3) isolation from mainstream, non-transgender society, which may curtail educational and vocational potential; and (4) the assumption of the medical and surgical risks of transition without benefit. In addition to these indirect harms, there is also the possibility that this type of gender dysphoria, with the subsequent drive to transition, may represent a form of intentional self-harm. Promoting the affirmation of a declared gender and recommending transition (social, medical, surgical) without evaluation may add to the harm for these individuals as it can reinforce the maladaptive coping mechanism. Furthermore, the length of time before the AYA accepts treatment for trauma or mental health issues, and interferes with the development of healthy, adaptive coping mechanisms. It is especially critical to differentiate individuals who would benefit from transition from those who would be harmed by transition before proceeding with treatment.

Reflections

Clinicians need to be aware of the myriad of barriers that may stand in the way of making accurate diagnoses when an AYA presents with a desire to transition including: the developmental stage of adolescence; the presence of subcultures coaching AYAs to mislead their doctors; and the exclusion of parents from the evaluation. In this study, 22.3% of AYAs had been exposed to online advice about what to say to doctors to get hormones, and 17.5% to the advice that it is acceptable to lie to physicians; and the vast majority of parents were reasonably sure or positive that their child misrepresented their history to their doctor or therapist. Furthermore, although parents may be the most knowledgeable informants on matters of their own child’s developmental, medical, social, behavioral, and mental health history- and quite possibly because they are the most knowledgeable- they are often excluded from the clinical discussion by the AYAs, themselves. An AYA telling their clinician that their parents are transphobic and abusive but not shown may mean that the parents are transphobic and abusive. However, the findings of this research indicate that it is also possible that the AYA calls the parent transphobic and abusive because the parent disagrees with the child’s self-diagnosis, has expressed concern for the child’s future, or has requested that the child be evaluated for mental health issues before proceeding with treatment.

The conclusion of this exploratory study is that clinicians need to be very cautious before relying solely on self-report when AYAs seek social, medical or surgical transition. Adolescents and young adults are not trained medical professionals. When AYAs diagnose their own symptoms based on what they read on the Internet and hear from their friends, it is quite possible for them to reach incorrect conclusions. It is the duty of the clinician, when seeing a new AYA patient seeking transition, to perform their own evaluation and differential diagnosis to determine if the patient is correct or incorrect in their self-assessment of their symptoms and their conviction that they would benefit from transition. This is not to say that the convictions of the patient should be dismissed or ignored, some may ultimately benefit from transition. However, careful clinical exploration should not be neglected, either. The patient’s history being significantly different than their parents’ account of the child’s history should serve as a red flag that a more thorough evaluation is needed and that as much as possible about the patient’s history should be verified by other sources. The findings that the majority of clinicians described in this study did not explore trauma or mental health disorders as possible causes
of gender dysphoria or request medical records in patients with atypical presentations of gender dysphoria is alarming. The rapid recognition of clinicians’ behavior of communicating with their patients’ parents, primary care physicians, and psychiatrists betrays a resistance to triangulation of evidence which puts AYAs at considerable risk.

It is possible that some teens and young adults may have requested that their discussions with the clinicians addressing gender issues be kept confidential from their parents, as is their right (except for information that would put themselves or others at harm). However, maintaining confidentiality of the patient does not prevent the clinician from listening to the medical and social history of the patient provided by the parent. Nor does it prevent a clinician from accepting information provided by the patient’s primary care physicians and psychiatrists. Because adolescents may not be reliable historians and may have limited awareness and insight about their own emotions and behaviors, the inclusion of information from multiple informants is often recommended when working with adolescents. One must take into account the inclusion of information from parents if a patient reports that a family member (prior and current), that the clinician would explore this with the patient and encourage them to reconsider. At the very least, if a patient asks that all information from parents and medical sources be disregarded, it should raise the suspicion that what the patient is presenting may be less than forthcoming and the clinician should proceed with caution.

The argument to surface from this study is not that the insider perspectives of AYAs presenting with rapid-onset gender dysphoria should be set aside by clinicians, but that the insights of parents are a pre-requisite for robust triangulation of evidence and fully informed diagnosis. All parents know their growing children are not always right, particularly in the almost universally tumultuous period of adolescence. Most parents have the awareness and humility to know that even as adults they are not always right themselves. When an AYA presents with rapid-onset gender dysphoria it is incumbent upon all professionals to fully respect the young person’s insider perspective but also, in the interests of safe diagnosis and avoidance of clinical harm, to have the awareness and humility themselves to engage with parental perspectives and triangulate evidence in the interest of validity and reliability.

The strengths of this study include that it is the first empirical description of a specific phenomenon that has been observed by parents and clinicians [81] and that it explores the psychosocial context of youth who have recently identified as transgender with a focus on vulnerabilities, co-morbidities, peer group interactions, and social media use. This research provides additional insights about the dramatic increases seeking care for gender dysphoria, the recent explosion of the sex ratio for adolescents seeking care, and the new clinical presentation of natal females having their gender dysphoria symptoms observed to begin during or after puberty (in the absence of readily observable indicators of childhood gender dysphoria).

Additionally, the qualitative analysis of responses about peer group dynamics provides a rich illustration of AYA intra-group and inter-group behaviors. This research also provides a glimpse into parent perceptions of clinician interactions in the evaluation and treatment of AYAs with an adolescent-onset (or young adult-onset) gender dysphoria symptoms.

The limitations of this study include that it is a descriptive study with the purpose of delineating previously unrecognized specific population of AYAs identifying as transgender and developing hypotheses about the origins and significance of rapid-onset gender dysphoria (ROGD). This is not a prevalence study and does not attempt to evaluate the degree to which this presentation of a socially mediated onset of gender dysphoria or the use of the drive to transition as a maladaptive coping mechanism is widespread in the population. Gathering more data on the topics introduced is a key recommendation for further study. It is not uncommon for first, descriptive studies, especially when studying a population or phenomenon where the prevalence is unknown, to use targeted recruitment to the population of interest criteria, recruitment could be difficult to cases meeting the criteria that are likely to have eligible participants. For example, in the first descriptive study about children who had been socially transitioned, the authors recruited potential subjects from a gender expansive camps and gender conferences where parents who supported social transition for young children might present and the authors did not seek out communities where parents might be less inclined to find social transition for young children appropriate [82]. In the same way, for the current study, recruitment was targeted primarily to sites where parents had described the phenomenon of a rapid onset of gender dysphoria because those might be communities where such cases could be found. The generalizability of the study must be carefully delineated based on the recruitment methods, and, like all first descriptive studies, additional studies will be needed to replicate the findings. The websites that were used for recruitment are sites which specifically offer to support parents worried about their transgender-identifying children and the population viewing these websites may be different from populations viewing websites that promote a "gender-affirming" perspective and both populations may differ from a broader general population in their attitudes about transgender-identified individuals.

It would be most accurate to characterize the differences between parents viewing the websites used for recruitment and parents viewing websites that promote a gender-affirming perspective as parents with a difference of opinion about how best to evaluate and treat gender dysphoric children and adolescents, with the former favoring judicious use of transition and the latter favoring a liberal use of transition. However, some may argue that the parents recruited from the websites used might be more oppositional to transgender-identified individuals in general. To address this potential concern, respondents were asked specifically whether they believe that transgender people deserve the same rights and protections as others and 88.2% of respondents gave affirmative answers to the question which is consistent with the 89% affirmative response reported in a US national poll [83]. All self-reported results have the potential limitation of social desirability bias. However, comparing this self-report sample to the national self-report samples [85], the results show similar rates of support. Therefore, there is no evidence that the study sample is appreciably different in support of the rights of transgender people than the general American population. It is also important to note that recruitment was not limited to the websites where the information about the study was first posted. Snowball sampling was also used so that any person viewing the recruitment information was encouraged to share the information with any person or community where they thought there could be potentially eligible participants, thus substantially widening the reach of potential respondents. In follow up studies on this topic, an even wider variety of recruitment sources should be attempted.

Another limitation of this study is that it included only parental perspective. Ideally, data would be obtained from both the parent and the child and the absence of either perspective paints an incomplete account of events. Input from the youth would have yielded additional information. Further research that includes data collection from both parent and child is required to fully understand this condition. However, because this research has been produced in a climate where the input from parents is often neglected in the evaluation and treatment of gender dysphoric AYAs, this research supplies a valuable, previously missing piece to the jigsaw puzzle. If Hypothesis 2 is correct that rapid-onset gender dysphoria (ROGD) represents an ego-syntonic maladaptive coping mechanism for AYAs, data from parents are especially important because affected AYAs may be so committed to the maladaptive coping mechanism that their ability to assess their own situation may be impaired. Furthermore, parents uniquely can provide data on the development of parental and patient gender identity; the presence of readily observable childhood indicators of gender dysphoria are especially relevant to the diagnosis. There are, however, obvious limitations to relying solely on parent report. It is possible that some of the participating parents may not have noticed symptoms of gender dysphoria before their AYA’s disclosure of a transgender identity; could have been experiencing shock or grief from the disclosure; or even could have chosen to deny or obscure knowledge of long term gender dysphoria. Readers should hold this possibility in mind. Regardless, the 200 plus responses appear to have been prepared carefully and were rich in detail, suggesting they were written in good faith and that
parents were attentive observers of their children's lives. Although this research adds the necessary component of parent observation to our understanding of gender dysphoria in adolescents and young adults, future study in this area should include both parent and child input.

This research does not imply that no AYAs who become transgender-identified during their adolescent or young adult years had earlier symptoms nor does it imply that no AYAs would ultimately benefit from transition. Rather, it suggests that not all AYAs presenting at these vulnerable ages are correct in their self-assessment of the cause of their symptoms; some may be employing a drive to transition as a maladaptive coping mechanism; and that careful evaluation is essential to protect patients from the clinical harms of over-treatment and undertreatment. More research is needed to determine the incidence, prevalence, persistence and desistance rates, and the duration of gender dysphoria for adolescent-onset gender dysphoria in general and for rapid-onset gender dysphoria, specifically. Adolescent-onset gender dysphoria is sufficiently different from early-onset of gender dysphoria that persists or worsens at puberty and therefore, the research results from early-onset gender dysphoria should not be considered generalizable to adolescent-onset gender dysphoria. It is currently unknown whether the gender dysphonias of adolescent-onset gender dysphoria and of rapid-onset gender dysphoria are transient, temporary or likely to be long-term. Without the knowledge of whether the gender dysphoria is likely to be temporary, extreme caution should be applied before considering the use of treatments that have permanent effects such as cross-sex hormones and surgery. Research needs to be done to determine if affrming a newly declared gender identity, social transition, puberty suppression and cross-sex hormones can cause an iatrogenic persistence of gender dysphoria in individuals who would have had their gender dysphoria resolve on its own and whether these interventions prolong the duration of time that an individual feels gender dysphoric before desisting. There is also a need to discover how to diagnose these conditions, how to treat the AYAs affected, and how best to support AYAs and their families. Additionally, analyses of online content for pro-transition sites and social media should be conducted in the same way that content analysis has been performed for pro-eating disorder websites and social media content [32].

Conclusion

Rapid-onset gender dysphoria describes a phenomenon where the development of gender dysphoria is observed to begin suddenly during or after puberty in an adolescent or young adult who would not have met criteria for gender dysphoria in childhood. ROGD appears to represent an entity that is distinct in etiology from the gender dysphoria observed in individuals who have previously been described as transgender. It is plausible that ROGD represents an ego-syntonic maladaptive coping mechanism for some AYAs and that peer group and online influences may contribute to its development. It is unknown whether the gender dysphoria of rapid-onset gender dysphoria is temporary or likely to be long-term. The elevated number of friends per friendship group who became transgender-identified, the pattern of cluster outbreaks of transgender-identification in these friendship groups, the substantial percentage of friendship groups where the majority of the members became transgender-identified, and the peer group dynamics observed all serve to support the plausibility of social and peer contagion for ROGD. The worsening of mental well-being and parent-child relationships and behaviors that isolate teens from their parents, families, non-transgender friends and mainstream sources of information are particularly concerning. More research is needed to better understand rapid-onset gender dysphoria, its implications, and scope.

Supporting information

S1 Appendix. Survey instrument. [PDF]
https://doi.org/10.1371/journal.pone.0202330.s001

S2 Appendix. COREQ Checklist. [PDF]
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