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A critical commentary on 'rapid-onset gender dysphoria'

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Abstract

The term 'rapid-onset gender dysphoria' (ROGD) was coined in 2016 to describe an alleged epidemic of youth coming out as trans 'out of the blue' due to social contagion and mental illness. The term reflects a deliberate attempt to weaponise scientific-sounding language to dismiss mounting empirical evidence of the benefits of transition. This article offers an introduction to the theory of ROGD and its history, presents a detailed critique of the empirical and theoretical claims associated with the theory, and highlights structural concerns with the ROGD discourse. The article argues that claims associated with ROGD, including assertions of declining mental health and degrading familial relationships following coming out, are best explained by the leading ROGD study's recruitment of parents from transantagonistic websites against a background of growing visibility and social acceptance of trans people. ROGD theory is best understood as an attempt to circumvent existing research demonstrating the importance of gender affirmation, relying on scientific-sounding language to achieve respectability.

Keywords

gender affirmation, gender identity, rapid-onset gender dysphoria, social contagion, trans youth

The notion of transgender youth coming out 'out of the blue' following exposure to trans communities is not new, but only recently coalesced into the politicised pseudo-diagnostic category of rapid-onset gender dysphoria (ROGD). Introduced in 2016, the term reflects a deliberate attempt to weaponise scientific-sounding language to dismiss mounting empirical evidence of the benefits of transition for youth (see e.g. Durwood et al., 2017; Lopez et al., 2017; Olson et al., 2016; Telfer et al., 2018; Turban et al., 2020; What We Know, n.d.). By offering a critical account of the social process by which the concept of ROGD was created and propagated and by drawing parallels to the political mobilisation of the scientific-sounding language of Parental Alienation Syndrome and False Memory Syndrome, this article contributes to wider sociological debates on the nature of scientific discourse.

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ROGD is alleged as distinct from traditional presentations of gender dysphoria such as early-onset (onset prior to puberty) and late-onset gender dysphoria (onset at or after puberty). According to ROGD theory, young persons who have shown no prior indication of gender dysphoria would suddenly begin to mistakenly believe that they are transgender. ROGD would be attributable to social contagion (the spreading of behaviour from one person to another through imitation), and especially through exposure to trans internet communities in youth predisposed to false beliefs (Bailey & Blanchard, 2017). Theorists of ROGD have argued that medical transition is unlikely to benefit members of this subgroup and may even harm them due to the causal relationship to social contagion and psychological vulnerability (Littman, 2018; Marchiano, 2017a). In the discourse surrounding ROGD, the desire to transition is frequently attributed to the devaluation of womanhood and sexualisation of women's bodies. The voices of trans teenagers alleged to have ROGD are conveniently absent from writings promoting the theory.

ROGD has seen an uptake among clinicians associated with the corrective approach, which aims at reducing the likelihood of youth growing up trans and has been likened to conversion therapy (Pediatric and Adolescent Gender Dysphoria Working Group, n.d.; Temple Newhook et al., 2018, p. 220; Zucker et al., 2012). While the corrective approach long focused on pre-pubescent children whose gender identity is claimed to be malleable, ROGD theory offers an excuse to extend the corrective approach to teenagers and young adults. Attempts to change gender identity and/or promote identification with sex assigned at birth has been widely opposed by professional associations (Ashley, n.d.; Coleman et al., 2012; UKCP et al., 2017).

This article aims to introduce readers to the construct of ROGD and its methodological and interpretive flaws. Despite professing to be scientific, observations associated with ROGD are best explained without positing a new clinical subgroup with pathological roots. ROGD theory is best understood as an attempt to circumvent existing research that demonstrates the importance of gender affirmation, relying on scientific-sounding language to achieve respectability. In the first section, I provide a short overview of the history of ROGD theory. In the second section, I evaluate the plausibility of empirical and theoretical claims made by proponents of ROGD theory. In the third section, I make three structural remarks about the broader social discourse underpinning ROGD.

A short history of ROGD theory

The first recorded use of 'rapid-onset gender dysphoria' was 2 July 2016 in a post on the blog 4thWaveNow, which is dedicated to opposing gender-affirmative care for trans youth. The post invited parents of children who evidenced 'a sudden or rapid development of gender dysphoria beginning between the ages of 10 and 21' to participate in a study by Lisa Littman, then an adjunct assistant professor of preventive medicine at the Icahn School of Medicine at Mount Sinai, New York (4thWaveNow, 2016). The study also recruited participants via Transgender Trend and Youth Trans Critical Professionals, organisations dedicated to opposing 'trans ideology', giving rise to serious concerns about sampling bias (Restar, 2020). The study, based exclusively on parent reports, was first published as a poster abstract in the *Journal of Adolescent Health* (Littman, 2017)

and subsequently as an article in *PLoS ONE* in August 2018 (Littman, 2019).[1] The study described ROGD as a new presentation of gender dysphoria, grounded in social contagion.

While a few articles suggesting a link between youth coming out as trans and social media were published before the study's poster abstract (4thWaveNow, 2016; Marchiano, 2016), references to social contagion drastically increased after it was published. Most noteworthy in the early phase between publication of the abstract and full study are essays by Lisa Marchiano (2017a), and Bailey and Blanchard (2017). Marchiano provided feedback to Littman throughout the drafting and submission process of the full study, while Bailey and Blanchard's work has long been criticised for perpetuating stereotypes and prejudices against trans women, notably suggesting that LGBQ trans women's primary motivation for transitioning is sexual arousal (Armstrong, 2004; Serano, 2010; see also Serano, this collection). Shortly after Bailey and Blanchard's article was published on 4thWaveNow, Barbara Kay (2017) wrote about ROGD in the *National Post*, Canada's leading conservative newspaper. Articles in newspapers such as the Canadian *Globe and Mail* (Soh, 2018), *The Times* in the UK (Turner, 2018) and *The Australian* (Lane, 2019) later followed, both before and after the full study was published.

Later in 2017, ROGD begun being mentioned in academic publications. Controversial Canadian psychologist Kenneth Zucker, whose clinic was closed in 2015 amidst allegations of engaging in conversion practices, referred to Littman's poster presentation in two publications (Zucker, 2017, 2018), whereas Marchiano has published a peer-reviewed article on the theory (2017b), largely based on a previous online essay. Littman's full study has since been cited in dozens of articles, commentaries and letters to the editor. The study has also influenced policy, with the conservative South Dakota house of representatives passing a Bill that would prohibit teaching students about gender dysphoria out of fear of social contagion (Lang, 2019). The Bill was later blocked at the state senate.

Although ROGD was rapidly adopted in circles that were critical of (and often hostile to) gender-affirmative care, it was also subject to strong criticism from trans health researchers and trans communities. Less than two weeks after publication, the journal announced that it would conduct a post-publication review. The review led the journal to publish a correction (Littman, 2019), a formal comment (Brandelli Costa, 2019), and an apology to trans communities (Heber, 2019). The corrected version of the paper better highlighted that the study does little more than generate new hypotheses for future testing and cannot be claimed to establish or validate the existence of ROGD. Despite this acknowledgement, opponents of gender-affirmative care continue to cite the study as evidence of ROGD's existence, and Lisa Littman herself has recently claimed that the study supports the ROGD hypothesis (Kay, 2019).

Empirical and theoretical claims associated with ROGD

Proponents of the theory view it as a new phenomenon that is distinct from traditional late-onset gender dysphoria, involving the spread of false belief caused by underlying mental illness, sexism and internalised homophobia. A degradation in mental health and

parent–child relationship is said to follow coming out, as ROGD youth aren't 'really' trans and their underlying psychosocial problems are not attended to. Because of these beliefs, proponents of ROGD theory believe that gender-affirmative care is tantamount to abuse and that trans identities should instead be actively discouraged among these youth (Rosario Sánchez et al., 2019). In this section, I critically assess the empirical and theoretical claims associated with ROGD theory and argue that they are either unsubstantiated or banal.

Distinguishing ROGD from traditional late-onset gender dysphoria

According to proponents of ROGD, recent years have been the stage of an explosion of youth 'presenting with dysphoria "out of the blue" without ever having expressed any gender variance before', a phenomenon that 'was virtually unheard of until a few years ago' (Marchiano, 2017b, p. 348). In Lisa Littman's study, parents reported their children coming out as trans at 15.2 years old on average (2018, p. 2). Contradicting this proclaimed novelty, available data suggest that as many as 40% of trans adults begin to feel like they may not be cisgender at or after 11 years old, and 19% report beginning feeling that way after 15 years old (James et al., 2016). An average coming out age of 15.2 years old is far from unusual, especially given the common lag between realising or privately processing one might be trans and coming out.

Accounts of ROGD often fail to provide a viable clinical rationale for excluding the classification of late-onset gender dysphoria, a well-documented clinical presentation. According to the DSM-5 (American Psychiatric Association, 2013, pp. 455–456):

> Late-onset gender dysphoria occurs around puberty or much later in life. Some of these individuals report having had a desire to be of the other gender in childhood that was not expressed verbally to others. Others do not recall any signs of childhood gender dysphoria. For adolescent males [*sic*] with late-onset gender dysphoria, parents often report surprise because they did not see signs of gender dysphoria during childhood. . . . Parents of natal adolescent females [*sic*] with the late-onset form also report surprise, as no signs of childhood gender dysphoria were evident.

Take the example of Noah, a 'strikingly good looking' trans adolescent whom clinicians Marina Bonfatto and Eva Crasnow (2018) present as an example of ROGD. Without clear reasons, they hypothesise that Noah's gender dysphoria is caused by premature sexualisation of his changing 'female' body and by his mother's hostility towards femininity. Yet nothing in Noah's clinical presentation was unusual from the perspective of late-onset gender dysphoria, including disagreement between Noah and his parents regarding early childhood gender non-conformity.

Bailey and Blanchard (2017) have explained their motivation for viewing ROGD as a new clinical presentation by associating traditional late-onset gender dysphoria with autogynephilia (see Serano, this collection), a discredited theory which only applies to people assigned male at birth and which posits fetishistic underpinnings to gender dysphoria (Bettcher, 2014; Moser, 2009, 2010; Serano, 2010). Since 'traditional' late-onset gender dysphoria is nearly exclusively transfeminine, this means trans youth who are assigned female at birth must fall into a new category, hence ROGD.

The corrected version of Littman's study acknowledges that ROGD and late-onset gender dysphoria are not mutually exclusive, but nevertheless posits ROGD as a distinct phenomenon by pointing to historically low rates of late-onset gender dysphoria among youth assigned female at birth at gender identity clinics. However, that explanation is unsatisfactory insofar as clinic populations may not reflect overall trans populations: adults assigned male at birth have long been much more common at gender identity clinics despite roughly equal proportions in the overall population (James et al., 2016).

Despite Marchiano's descriptor 'out of the blue', there is nothing particularly significant or novel about the absence of pre-pubertal gender dysphoria. The DSM-5's description of late-onset gender dysphoria acknowledges that individuals may present with or without recalled childhood gender dysphoria. Puberty is known for its role in intensifying or unearthing gender dysphoria in part due to changes and development in secondary sexual characteristics (Steensma et al., 2011). Given what we know, there is no compelling reason to view suggested cases of ROGD as anything but commonplace late-onset gender dysphoria.

Trans as a psychic epidemic

The thesis of social contagion is allegedly supported by the stark rise in teenagers referred to gender identity clinics, as well as patterns of LGBT+ friend groups, internet usage and social isolation. However, none of these corroborate the existence of social contagion or psychic epidemic.

The stark rise in referrals is most likely attributable to more trans people seeking transition-related care in a context of increased trans visibility. The intensity of gender dysphoria and prevalence of mental health issues have remained stable at gender identity clinics in recent years (Arnoldussen et al., 2019), suggesting that the clinical population has not substantially changed. On the other hand, cultural determinants of access to transition-related care such as mainstream visibility are likely to have outsized effects on referral rates since the gender identity clinic population is exceedingly small compared to the overall number of trans people (Ashley, 2019c).

Lisa Littman's parent respondents reported that on average, 3.5 individuals in their child's friend group came out as trans and 63.5% of the children increased their internet and social media usage immediately prior to coming out (Littman, 2018, pp. 17, 20), leading proponents of the theory to claim that the armchair-diagnosed children were 'strongly influenced by their peers and by the media, who are promoting the transgender lifestyle as popular, desirable and the solution to all of their problems' (Parents of ROGD Kids, n.d.). The theory was said to be confirmed by how many of them increased in popularity after coming out and belonged to friend groups that 'poked fun' at cisgender, heterosexual people.

Despite the claims put forward by proponents of ROGD, these numbers are unsurprising. While Littman's figure of 3.5 trans friends per group may appear large given the relative rarity of trans people, the variables are not independent and trans youth will frequently seek out friend groups or online content that reflects their gender questioning. In one example given by Littman (2018, p. 17), the friend group of the trans teenager was known for regularly discussing gender and sexuality. Youth are not dropped

into a sea of trans-affirming content, but actively seek it out. Given that relatively few people seriously question their gender, it is unsurprising that trans people would be overrepresented among those who questioned their gender and navigated cyberspace and meatspace – the physical world outside of cyberspace – accordingly. The importance of the internet as a source of support and information for trans people has long been known and was already being observed in the 1990s (Whittle, 1998). Moreover, many queer and trans people tend to be fascinated by queer and trans folk prior to understanding their own identity, often leading them to orbit and form groups around one or two individuals who are out to other young people, but maybe not to their parents. These groups are often critical to the development of positive self-understanding, emboldening youth to admit their gender identity and/or sexual orientation to themselves and, later, to others (Kuper et al., 2018).

Vulnerability and mental illness

For the hypothesis of social contagion to be plausible, being trans must hold a promise strong enough to overcome stigma and the pull of one's true gender identity – otherwise, youth would be unlikely to mistakenly believe they are trans. Under ROGD theory, the appeal of transition lies in offering a quick solution for an underlying psychological distress rooted in mental illness, and trans identities are depicted as 'a symptom of severe psychological pain or dysfunction' (Parents of ROGD Kids, n.d.) or as an attempt to resolve 'all unhappiness, anxiety, and life problems' (Bailey & Blanchard, 2017).

These remarks are supported by reference to allegedly abnormally high reported mental illness rates of 75% (Kaltiala-Heino et al., 2015, p. 5) and 62.5% (Littman, 2018, p. 14) among trans teenagers and especially trans teenagers assigned female at birth. The reported mental illnesses consisted predominantly of depression and anxiety. Contrary to assumption, the rates of mental health issues reported in both studies were in no way abnormal given what is known of trans mental health (Dhejne et al., 2016; James et al., 2016; Reisner et al., 2015). It is well-known that trans people suffer from high rates of anxiety and depression due to transphobia (Bauer et al., 2015) and that puberty exacerbates gender dysphoria (Steensma et al., 2011), leading to higher levels of distress among post-pubescent populations as compared to children. While mental health issues are common among trans people, rates of mental health issues in gender identity clinic referrals have remained substantially the same since 2000 (Arnoldussen et al., 2019), contradicting the claim of novelty underpinning ROGD theory.

That trans identity is pushed onto teenagers as a solution to all their problems also purportedly finds support in the Littman (2018, p. 21) study's claim that 28.7% of youth received online advice that they would never be happy if they didn't transition. The inverse statistic is more telling, however: a strong 71.3% majority of teens purported to have ROGD were never told that they needed to transition in order to be happy. With regard to the remaining 28.7% minority, the context and frequency of the advice was not reported, and so included youth who were only advised to transition after they extensively described their gender histories and experiences of dysphoria, together with youth who only received this advice once or twice, a far cry from peer pressure.

Transitioning as a flight from womanhood

In her 1994 introduction to second edition of *The Transsexual Empire*, Janice Raymond explained that the putative rarity of transmasculine individuals is due to the presence of feminism as a political outlet for frustration with rigid gender roles among women. According to her, trans men aren't as common as trans women because they can funnel their frustrations with gender into feminism. ROGD is instead being depicted as a flight from womanhood motivated by rigid gender roles and the sexual objectification of cis female bodies. Turning to why a trans teenager had a male gender identity, Bonfatto and Crasnow speculated that it was due to 'objectification and premature sexualisation' and his mother's alleged belief 'that being male is preferable to the embracing and celebration of femininity' (2018, p. 43). As is typical of public accounts of ROGD, links to internalised misogyny were purely speculative and not rooted in the teenager's own words. Sexual trauma is another oft-posited source of trans identities. Littman (2018, pp. 2, 14) reported sex or gender-related trauma in 30.1% of teens, 82.8% of whom were assigned female at birth. The absence of control groups and an overbroad definition of sex or gender-related trauma, which included sexual harassment, relationship issues, and break ups, undermine the statistic's utility. Additionally, Littman doesn't account for the fact that trans and gender non-conforming people are at a higher risk of being targeted by sexual harassment and violence (James et al., 2016).

These explanations are presented argumentatively and validated by the stark, 'unexplained' rise in clinical referrals of teenagers assigned female at birth (Aitken et al., 2015). However, the fact that it remains unexplained doesn't relieve ROGD theorists from adequately supporting their preferred explanation. What has changed since 1994 that made feminism no longer a viable political outlet, despite the proliferation of body acceptance movements? Are they suggesting that feminist movements have not only ceased, but regressed significantly?

As previously mentioned, gender identity clinic populations are not representative of the overall trans population. The stark size difference (in the order of magnitude of 20:1) between overall trans populations and clinic populations makes cultural factors impacting referral patterns the most plausible explanation for shift in assigned sex ratios (Ashley, 2019c). If the trans population is 20 times larger than the clinic population, 5% additional trans people seeking referrals corresponds to a 100% increase in clinical referrals. As Arnoldussen et al. (2019) have reported, the intensity of gender dysphoria and prevalence of mental health issues in gender identity clinics have remained stable despite the changing picture of referrals.

Given the various factors which are expected to play a role in shifting gender ratios in gender identity clinics, insufficient support exists for the claim that there is an unexplained and unexpected rise in transgender teenagers assigned female at birth. The attribution of this rise to internalised misogyny and responses to sexual trauma is unsubstantiated, and cultural factors impacting referral rates are more likely culprits than changes in the overall trans population.

Where are the butches?

Hand in hand with the claim that transmasculinities are a 'flight from womanhood' comes the claim that they are rooted in lesbophobia. Butch women – and, to a lesser

extent, feminine gay men – are said to be pushed into transition by a society that is more tolerant of straight transgender identities than of cisgender LGBQ people.

One might wonder which society is more tolerating of trans people. Trans psychology has a long history of promoting cisgender gay outcomes over transgender ones (Zucker et al., 2012). Psychiatrist Richard Green, the former head the UCLA Gender Identity Research Clinic, stated as recently as 2017 that he is 'convinced that it is a helluva lot easier negotiating life as a gay man or lesbian woman than as a transwoman or transman' (Green, 2017, p. 82), a position that is reflected in the attitudes of parents of trans children found in case reports. On nearly all metrics, trans people are less accepted than cis LGBQ people (Ashley, 2019d). Most tellingly, 64% of trans and non-binary youth in the United States report that their families make them feel bad about their identity, compared to 34% of cisgender LGBQ youth (Human Rights Campaign, 2018, p. 8). Considering how few trans youth are straight – between 5% and 16.8% (Ashley, 2019d; Human Rights Campaign, 2018, p. 38) – it is difficult to suggest that transition is motivated by the desire to be straight, at least in the global North. Despite these figures and their own acknowledgement that it is harder being trans, trans health theorists have long posited that trans identities are an attempt to avoid being gay, leading to sexual orientation featuring prominently in early typologies. Those theories have since been largely abandoned by researchers in part due to more serious engagement by mental health professionals with trans accounts, which radically contradict this early work (see e.g. Bettcher, 2014; Serano, 2010).

Studies on the proportion of pre-pubertal youth referred to gender clinics who grow up trans have been used in support of the view that trans affirmation is homophobic, since most children at those clinics grow up to be cisgender and LGBQ (Temple Newhook et al., 2018). These studies have been intensely criticised for failing to distinguish gender non-conformity from being transgender, impugning their conclusions. As many as 90% of the subjects already identified with the sex they were assigned at birth (Olson, 2016, p. 156). Because these studies are concerned with pre-pubertal youth rather than adolescents and adults, which are the focus of ROGD theory, their relevance to ROGD was already tenuous. A study by DeLay et al. (2018) titled 'The Influence of Peers During Adolescence: Does Homophobic Name Calling by Peers Change Gender Identity?' has also been used to support the claim that transgender identities develop due to homophobia. However, this relied on a grave misinterpretation: what the study found was that gay boys attacked for their gender non-conformity felt less affinity with boys than girls, a somewhat unsurprising conclusion given that most of them were targeted precisely because they were effeminate. The study used the term 'gender identity' completely differently from how it is used in trans contexts.

Anecdotal references to worries among lesbians are also presented as evidence of gender transition's lesbophobic underpinnings: 'Lesbians are particularly worried about the teen trans trend, as most girls coming out as transgender are same-sex attracted. Many in the lesbian community are distraught to notice that butch lesbians are quickly disappearing' (Marchiano, 2017b, p. 350). Claims that butches are disappearing and becoming trans men are far from new. Much ink has been spilled over the 'FTM/Butch Border Wars' of the 1990s and early 2000s, even making it to *The New York Times* (Vitello, 2006). Despite purporting to be a new phenomenon, ROGD theory largely falls

in line with rhetoric from the 1990s and 2000s. While many people who identified as butch women in the past are now transgender men or non-binary, it may have more to do with the growing availability and intelligibility of transgender identities than lesbophobia (Lee, 2001). Some trans men and non-binary folk continue to wear the butch label with pride and some of those who have abandoned it did so only because it is seen as a women-only label. Trans people's relationship to gender and sexuality labels is more complicated and messier than anti-trans activists suggest. Anecdotal worries do not provide evidence of lesbophobia.

The degradation of parent–child relationships and mental health

One of ROGD theory's central claims is that transition and gender affirmation makes teenagers purported to have ROGD worse off. The main evidence offered is found in Littman's (2018) parental reports of degrading mental wellbeing and familial relationships after coming out. In the study, parent respondents reported that their parent–child relationships had degraded in 57.3% of cases and that their child's mental wellbeing had deteriorated in 47.2% of cases (p. 22). This is unusual according to her, as 'existing research' on trans adults evidenced 'improved family relationships after coming out' in 61% of cases (Littman, 2017, p. S96) and is contrary to 'the narrative of discovering one's authentic self and then thriving' (Littman, 2018, p. 21). She does not provide a reference for the 61% figure.

Despite having come out an average of 15 months prior to their parents participating in the study, only 14 youth (5.5%) no longer identified as trans to their parents (p. 30). Of those 14, only 3 (1.2%) had begun transitioning and were counted as having detransitioned, in line with reported regret rates among trans adults (Dhejne et al., 2014; Wiepjes et al., 2018). It is worth noting, however, that detransition does not necessarily indicate regret (see Hildebrand-Chupp, this collection) and many youths who detransition are grateful for having had the opportunity to explore their gender identity (Ashley, 2019b; Turban & Keuroghlian, 2018; Turban et al., 2018).

While transition is strongly associated with improved mental health (What We Know, n.d.), the statistics must be reported in light of the Littman study's sampling from overtly transantagonistic groups (Restar, 2020). The difference is important because parental rejection of youth gender identity is causally related to deterioration of the parent–child relationship, as with any rejection of a component of youths' core sense of self. Given the context of dependency which structures teenager–parent dynamics, it is unsurprising that lack of acceptance leads to poor mental health, as was confirmed by at least one youth represented by the Littman study (Tannehill, 2018). It is well-known that poor parental acceptance of gender identity is one of the strongest predictors of suicidality among transgender people (Bauer et al., 2015).

While the phenomenon is undertheorised, coming out is anecdotally associated with temporary spikes in body and social gender dysphoria (MacKinnon, 2018; Price, 2019). Cultural meaning mediates experiences of body dysphoria. Much like how misgendering can feel more invalidating when you're actively trying to be read as a given gender, body dysphoria can also be magnified by social context. This distress, however, seems to decrease over time. Littman's observations may thus partly reflect an ephemeral

phenomenon. Alongside access to affirmation, social and medical transition are associated with better mental health in the long term (What We Know, n.d.).

The Littman (2018) study's reported degradation in mental health and familial relationships can readily be explained by the oppositional attitudes of its parental participants, coupled with the social and psychological difficulties that are unfortunately associated with coming out in a world that remains unwelcoming of trans people. The reported trend would, in all likelihood, be radically different were the respondents accepting of their children (Olson et al., 2016).

Opposition to gender affirmation and support for conversion practices

Giving away their political hand, many proponents of ROGD theory advocate for discouraging teenagers' gender identities and accuse affirming clinicians of being negligent, making thinly veiled threats of legal action (PADad, 2018). Despite a legal obligation to maintain patient confidentiality, professionals' unwillingness to discuss teenagers' cases with parents was cast as further evidence of negligence (Littman, 2018). Littman suggests that professionals could gather information from parents despite youths, some of whom were adults, asking that the clinician maintain confidentiality vis-a-vis their parents. Her perspective seems to underestimate the scope of the duty of confidentiality, which goes so far as to preclude doctors from acknowledging that a person is their patient without permission, let alone the content and context of their discussions (e.g. contemplating medical transition, discussing childhood gender history, etc.). Despite over 67.2% of the youth in the study expressing a desire for hormone replacement therapy, only 11.3% of them had accessed hormones (Littman, 2018, pp. 15, 30). This low rate, despite youths having come out on average 15 months prior is plausibly attributable to the combination of parental opposition and the commonly long delays in transition-related care.

Sources promoting ROGD theory routinely generalise opposition to transition regardless of whether individuals fall under its proposed developmental pathway. The website Parents of ROGD Kids, for instance, claims that '[p]rofessionals who accept an individual's self-diagnosis and propose medical interventions are negligent' and that '[m]edical intervention for gender dysphoria should be a last resort' (n.d.). Controversial clinicians Bailey and Blanchard recommend 'against hiring gender clinicians who are hostile to our typology', a typology which includes autogynephilia and ROGD (2017). An open-letter posted to 4thWaveNow goes in a similar direction, stating (PADad, 2018):

> At a minimum, you should be raising the bar and making selection criteria considerably more stringent before prescribing 'puberty blockers,' HRT and surgeries. Because these treatments have permanent effects on patients' bodies and minds, you should be first requiring alternatives to these treatments which are more reversible.

This newfound support for conversion practices, which aim at changing or discouraging the gender identities of trans individuals, is worrisome. In recent times, such approaches had been theoretically narrowed to pre-pubertal youth under the belief that adolescents and adults' gender identities are no longer malleable (Zucker et al., 2012). However, these same practitioners seem to be welcoming ROGD theory (Pediatric and Adolescent

Gender Dysphoria Working Group, n.d.) and have endorsed the return of conversion practices for adults (Zucker et al., 2016). Unsurprisingly, ROGD has also been mobilised by conservative groups who oppose laws banning conversion practices (e.g. National Task Force for Therapy Equality, 2018).

ROGD notwithstanding, conversion practices are deemed unethical by the World Professional Association for Transgender Health (WPATH) Standards of Care (Coleman et al., 2012) and opposed by many leading professional associations (Ashley, n.d.). They are associated with severe psychological distress and suicidality, including a 2.27-fold increase in lifetime suicide attempts (Turban et al., 2020). Gender affirmation and access to transition remain the dominant and most empirically supported approach to trans youth care (Ashley, 2019b; Lopez et al., 2017; Rafferty, 2018; Telfer et al., 2018).

Structural remarks on ROGD discourse

Testimonial injustice and the absence of adolescent trans voices

The voices of trans youth are noticeably absent from the ROGD literature. Littman's study was based on parental reports sampled from transantagonistic websites, a significant limitation which was severely downplayed prior to post-publication review. While parent reports are not unusual in social science research, the decision to rely solely on parental reports is puzzling given the heavy sample bias and the unreliability of parent reports in the context of poor familial relationships. The chronology of ROGD theory and the choice to advertise solely on transantagonistic websites have led some to suspect that Littman's exclusion of trans voices was informed by prejudice or ideological alignment. Denying trans people's epistemic agency and credibility is one of the ways in which transantagonistic attitudes are operationalised (Ashley, 2019a; Bettcher, 2009; McKinnon, 2017).

The rare times trans voices can be found in the ROGD literature, they are inescapably contradicted. To claims of being transgender from trans youth, the retort is that they are not qualified to self-assess (Littman, 2018) even though gender identity is not a medical diagnosis and is indeed something of which trans people have privileged knowledge (Ashley, 2019a; Richards et al., 2015). Despite disavowing the validity of self-diagnosis, Littman ironically relies on parental responses as a proxy for diagnosing both childhood and adolescent gender dysphoria (Restar, 2020). To the 63.8% of teens in the study who were reported as accusing their parents of transphobia, Littman points to parents' support of same-sex marriage and equal rights for trans people as evidence to the contrary. Yet, support for trans equal rights does not equate to social acceptance or substantive rights, nor acceptance of trans people in their immediate family. Political claims made by trans groups are regularly described as 'asking for special rights' by opponents (Radcliffe, 2013), enabling parents to maintain a facade of progressivism while remaining deeply transantagonistic.

To support the hypothesis of ROGD, it would have been essential to obtain youths' own perspectives as to their mental wellbeing and the perceived reasons for improvement or decline. Furthermore, if these youths' belief of being trans is an unhealthy coping mechanism, we would expect a significant rate of detransition. Yet despite having

come out on average 15 months ago, only 5.5% were reported to have re-identified with the sex they were assigned at birth and, of those, 78.6% had not taken steps towards social, legal, or medical transition (Littman, 2018). A common feature of reports of ROGD is that despite reporting bias and strong parental pressures against transition, most youth do not detransition, shedding serious doubt on ROGD's sweeping claims of a false belief epidemic.

Aetiology isn't destiny

Let us assume, for a moment, that there is indeed a new subgroup of youth who, having experienced trauma and mental illness, come to believe themselves to be trans as a maladaptive coping mechanism. It would not follow that social and/or medical transition is unethical or harmful. As Tey Meadow elegantly puts it (2018, p. 90):

> [I]t's not a huge leap to imagine that some forms of gender could be made of scar tissue, produced as much by trauma as by tenderness. But it's a quick and dangerous slide from thinking about gender deviance as compensatory and thinking it pathological.

Not all coping mechanisms are unhealthy. Even if it were the case that for some people believing oneself transgender is a coping mechanism brought on by trauma, transition may still be indicated. If the rise in transgender identities evidences social contagion – a claim I have shown to be unsubstantiated – it may yet be a healthy contagion. Rather than escapism, working from this premise, youth may simply be using available tools to deal with their problems, remaking themselves in the process. The overwhelming majority of youths mentioned in Littman's (2018) study continue to identify as trans. Describing Noah's alleged ROGD, Bonfatto and Crasnow go on to mention that he ended up taking puberty blockers and moving on to hormone replacement therapy, flourishing into a healthy trans adult: 'As his adolescence has drawn on he is functioning well and has moved on to university' (Bonfatto and Crasnow, 2018, p. 43). If identifying as trans could be described as a coping mechanism, none of the available evidence would suggest it being an unhealthy one.

Pathologising accounts of aetiology (the cause(s) of being trans) are as old as trans health itself (Pyne, 2014). Besides biological causes, mental illness and parental behaviour have commonly been posited. Even in recent years, proposed causes have included separation anxiety, autism-spectrum 'disorder', and parental transference of 'unresolved conflict and trauma-related experiences' (Zucker et al., 2012, pp. 378, 380). ROGD's proposal of mental illness and trauma as roots of trans identity is a familiar one.

Contrary to the assumption that aetiology is uniquely relevant to clinical ethics, many clinicians deem it unimportant (Vrouenraets et al., 2015). The primary focus should instead be on how to best support the individual. If we are concerned primarily for the wellbeing of adolescents, the cause of gender identity takes on a secondary or tertiary importance. The question we should ask is whether those said to have ROGD are harmed by gender-affirmative care. So far, all evidence points to the opposite conclusion: supporting trans people's gender identities and facilitating access to transition-related care makes them better off (Bauer et al., 2015; Turban et al., 2020; What We Know, n.d.).

Positing a traumatic and pathological aetiology does not overturn existing evidence in favour of gender affirmation. Aetiology isn't destiny.

Circumventing science through pseudoscience

Built on unsound empirical bases and shaky theoretical foundations, ROGD exhibits features of a discursive strategy that mobilises scientific language to circumvent evidence that challenges the status quo. Parallels may be drawn between ROGD, Parental Alienation Syndrome and False Memory Syndrome (Dallam, 2001; Meier, 2009; Schuman & Galvez, 1996).

In 1985, Richard Gardner proposed Parental Alienation Syndrome to refute accusations of child abuse in custody litigation. Suggesting that as many as 90% of children in custody litigation suffered from the syndrome (Meier, 2009), Gardner suggested that vengeful mothers had enlisted and brainwashed their children into believing, repeating and fabricating untrue claims of abuse. The proposed syndrome was based on claimed clinical experience rather than scientific evidence (Meier, 2009), and has been extensively mobilised in custody cases to disclaim abusive behaviour.

Similarly, the False Memory Syndrome construct did not emerge from disinterested research. Instead, it was coined by the False Memory Syndrome Foundation, an organisation of parents accused of child sexual violence, in 1992 (Dallam, 2001). The foundation was created by Peter and Pamela Freyd after their daughter Jennifer Freyd, a respected specialist in memory research, accused Peter of sexual assault. Although false and distorted memories are known to be possible, FMS was predicated on false memories of child sexual violence having reached epidemic proportions due to recovered memory therapies. Without epidemiological evidence or viable means of distinguishing between false memories and recovered memories, the foundation's advocacy and research lent scientific credibility to numerous individuals accused of child sexual violence. Neither proposed syndrome was ever included in the DSM.

The three theories share important features: (1) an extant phenomenon, (2) new scientific language, (3) claims of an epidemic primarily based on anecdotal evidence, and (4) a reactionary party concerned by a challenge to the status quo. The strength of the rhetorical strategy lies in its simultaneous appeal to common sense phenomena and the authority of science. Memories can be defective or distorted. Children can develop unwarranted hostility toward a parent during divorce. People can transition for the wrong reasons. Yet in each case, the further claim of an epidemic that is added to these extant phenomena fails to attract credible evidence and conflicts with known data. Scientific language discursively bridges this evidentiary gap by profiting from the public's shortcomings in distinguishing good from bad (and pseudo-) science. In so doing, proponents of ROGD elevate anecdotal cases to scientific truth, rationalising opposition to social and medical transition. Even if, as with the now-flourishing Noah, it was evidently the right decision.

Epistemological violence and burden of proof

One way of understanding the fundamental problem with ROGD theory is through the notion of epistemological violence. Epistemological violence occurs when data

interpretations that have negative consequences for marginalised groups are selected despite the existence of alternative, equally (or more) plausible interpretations (Teo, 2010). From an ethical and epistemological standpoint, interpretations of data that do not perpetuate or reinforce marginalisation should be favoured over those that do.

The anecdotal and scientific data underpinning ROGD theory is best explained by the operative context of transantagonistic parenting against a background of growing visibility and social acceptance of trans people. Despite being presented as evidence of a new developmental pathway, studies such as Littman's (2018) are readily explainable using established knowledge, without relying on a host of unsupported and pathologising assumptions. As such, ROGD theory offers a conspicuous example of epistemological violence, relying on longstanding tropes of trans people as confused and mentally ill to legitimate opposition to social and medical transition.

Despite attempts to shift it onto proponents of gender-affirmative care, the burden of proof lies squarely on proponents of ROGD since they are seeking to displace the empirically backed consensus approach. Evidence only counts as supporting the existence of ROGD if it excludes the possibility of non-pathological, non-epidemic explanations – something that has yet to be offered. Unsurprisingly given the dearth of supporting evidence, many leading experts have rejected ROGD as lacking empirical support (Ashley & Baril, 2018; AusPATH, 2019; Gender Dysphoria Affirmative Working Group, 2018; WPATH, 2018). The post-publication clarification that Littman's article is merely hypothesis-generation rather than hypothesis-testing (Littman, 2019), besides its various flaws, further confirms this conclusion.

Conclusion

More panic than epidemic, proponents of ROGD paint themselves as a marginal group speaking truth to power. In sharp contrast, the theory has spread like wildfire since being coined a few years ago, making its way into national newspapers and being cited by writers, scholars and interest groups with a long history of hostility towards transgender people. As I hope to have shown, ROGD's concerning claims hide a barren empirical wasteland. Instead of a legitimate scientific hypothesis, ROGD is best understood as an attempt to mobilise scientific language to circumvent mounting evidence in favour of gender affirmation (Durwood et al., 2017; Lopez et al., 2017; Olson et al., 2016; Telfer et al., 2018; Turban et al., 2020; What We Know, n.d.) by positing a new clinical subgroup to whom the existing data do not apply. Since gathering new data takes years, this discursive strategy can in turn be used to justify opposing gender affirmation and pressuring youth to identify with the gender they were assigned at birth, a practice akin to conversion therapy.

Despite the facial neutrality of scientific language, the transantagonistic roots of ROGD are easily unearthed. Interposed between claims like '[i]dentifying as the opposite gender is NOT normal', 'she was female, and would never be otherwise' (Parents of ROGD Kids, n.d.), and 'I mean, you can't change your sex, right? It's scientifically impossible' (MacDonald, 2017), proponents of ROGD's self-narratives as accepting-but-concerned individuals cannot but be suspect.

Reports of an epidemic have been greatly exaggerated. Upon closer examination, ROGD reveals itself to be a construct mired in unfounded and prejudiced assumptions. It should be enthusiastically rejected.

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1. The original version of the study was replaced by a corrected version and is now available as a supplementary file to the correction notice.

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