

Article

In favor of Affirmative Psychology, review of the book “*Nadie nace en un cuerpo equivocado*” [*Nobody is born in the wrong body*]

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ABSTRACT

In the following pages, an analysis is made of the statements concerning affirmative therapy on trans people appearing in the book “*Nadie nace en un cuerpo equivocado: Éxito y miseria de la identidad de género*” [Nobody is born in the wrong body: the success and misery of gender identity] (Errasti & Pérez, 2022). To this end, studies are provided that refute the information presented in this manual on issues such as ROGD, detransitions, and the alleged laxity of the affirmative approach.

En favor de la Psicología Afirmativa, crítica del libro *Nadie nace en un cuerpo equivocado*

RESUMEN

En las siguientes páginas se realiza un análisis de las afirmaciones sobre la “Terapia Afirmativa” centrada en personas *trans*³ que aparecen en el libro “*Nadie nace en un cuerpo equivocado: Éxito y miseria de la identidad de género*” (Errasti y Pérez, 2022). Para ello se aportan los estudios que refutan las informaciones que este manual presenta sobre asuntos como el *ROGD*, las *detransiciones* o la supuesta laxitud del enfoque afirmativo.

Palabras clave

Transexualidad
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LGBT
Directrices

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2 Errasti and Pérez speak of “affirmative therapy”, not affirmative psychology. Under this term they sometimes refer to medical interventions and, at other times, to psychological therapy.

3 In this article, the nomenclature “trans” is preferred over “transsexual” or “transgender” in accordance with international guidelines.

Introduction

The book "Nadie nace en un cuerpo equivocado: Éxito y miseria de la identidad de género" [Nobody is born in the wrong body: the success and misery of gender identity] has generated a wave of reactions. Many professionals have shown their concern about the role that they will have to play if a trans law is passed in our country, believing that the aforementioned book makes a realistic diagnosis of the care for trans people promoted by the affirmative approach. Both at IPsyNet and in the different working groups of the *Colegios de Psicología* [regional psychology associations in Spain] we have received numerous queries from psychologists about the statements made in this manual. Thus, we think it is our obligation to clarify the inaccuracies and falsehoods that appear in this essay.

Of the ten chapters that make up the book, the first six are dedicated to queer philosophy (more precisely to "Queer Studies"), the seventh chapter talks about trans childhoods, and only the eighth chapter deals with the treatment of transsexuality from the perspective of affirmative therapy. Chapters nine and ten return to the queer theme. All that is related to this philosophical thought should be discussed with philosophers, the present analysis focuses on psychology, analyzing and discussing the statements of the seventh and eighth chapters that lack scientific validity and therefore should be rejected.

Rapid Onset Gender Dysphoria.

In the chapter dedicated to trans childhoods, ROGD (Rapid Onset Gender Dysphoria), a concept arising from the [Littman study \(2018\)](#), is discussed at length. This study was strongly criticized and even gave a name to a polemic (the "rapid-onset gender dysphoria controversy"). Forced to rectify by the journal PLOS ONE, Littman published the following:

"The post-publication review identified issues that needed to be addressed to ensure the article meets PLOS ONE's publication criteria. Given the nature of the issues in this case, the PLOS ONE Editors decided to republish the article, replacing the original version of record with a revised version in which the author has updated the Title, Abstract, Introduction, Discussion, and Conclusion sections, to address the concerns raised in the editorial reassessment. The Materials and methods section was updated to include new information and more detailed descriptions about recruitment sites and to remove two figures due to copyright restrictions. Other than the addition of a few missing values in Table 13, the Results section is unchanged in the updated version of the article."

In this respect, PLOS One's editor wrote

"The corrected article now provides a better context of the work, as a report of parental observations, but not a clinically validated phenomenon or a diagnostic guideline."

In other words, the conclusions of the original study were based on what parents thought, not on the presence of a professionally diagnosed disorder. The full correction can be read in ([Littman, 2019](#)) where it states:

"This study of parental observations and interpretations serves to develop the hypotheses that rapid-onset gender

dysphoria is a phenomenon and that social influences, parent-child conflict, and maladaptive coping mechanisms may be contributing factors for some individuals. Rapid-onset gender dysphoria (ROGD) is not a formal mental health diagnosis at this time. This report did not collect data from the adolescents and young adults (AYAs) or clinicians and therefore does not validate the phenomenon."

Apart from criticisms of internal validity ([Restar, 2020](#)), the only conclusion that Littman's work allows is that, from the parents' perspective, for many it seems as if their child "suddenly became trans." In fact, it is common for trans children not to inform their parents about their gender identity until they have fully mentally worked it out, and this leaves parents bewildered by the seeming suddenness of the event ([Sorbara et al., 2021](#)). Thus, many parents of trans children receive the news with surprise and do not know how to process what is happening. The evidence further demonstrates that the clinical data do not support the concept of ROGD ([Bauer et al., 2021](#)):

We did not find support within a clinical population for a new etiologic phenomenon of rapid onset gender dysphoria during adolescence. Among adolescents under age 16 years seen in specialized gender clinics, associations between more recent gender knowledge and factors hypothesized to be involved in rapid onset gender dysphoria were either not statistically significant, or were in the opposite direction to what would be hypothesized. This putative phenomenon was posited based on survey data from a convenience sample of parents recruited from websites, and may represent the perceptions or experiences of those parents, rather than of adolescents, particularly those who may enter into clinical care. Similar analyses should be replicated using additional clinical and community data sources. Our finding of lower anxiety severity/impairment scores in adolescents with more recent gender knowledge suggests the potential for longstanding experiences of gender dysphoria (or their social complications) playing a role in development of anxiety, which could also be explored in future research.

Finally, it should be recalled that the concept of "rapid onset gender dysphoria" has been widely rejected by the scientific community ([Coalition for the Advancement and Application of Psychological Science, 2021](#)).

"In 2021, the Coalition for the Advancement and Application of Psychological Science released a statement calling for the elimination of the concept of ROGD from clinical and diagnostic use, as "there are no sound empirical studies of ROGD and it has not been subjected to rigorous peer-review processes that are standard for clinical science." The statement also states that the term "ROGD" is likely to stigmatize and cause harm to transgender people, and that misinformation surrounding ROGD is used to justify laws suppressing the rights of transgender youth. The statement was cosigned by the American Psychiatric Association, the American Psychological Association, the Society of Behavioral Medicine, the Association for Behavioral and Cognitive Therapies, and the National Association of School Psychologists."

Conclusion: The statements made in the book analyzed on ROGD are completely lacking in scientific basis and validity.

The increase in the number of patients referred to gender units

At the beginning of the chapter on trans children, the authors show the increase in the number of children referred to these units as if this increase were indicative of an excess (p. 277-278⁴).

Gender clinics around the world report an increase in the number of referrals at younger ages and, in particular, of girls. Thus, for example, referring to the United Kingdom, whereas nine years ago only 40 girls were referred for sex transition treatment, that figure is now 1,806, an increase of 4,515 percent. Meanwhile, the number of boys increased from 56 to 713 in that same time. A reference from Sweden speaks of a 1,500 percent increase in incidence. Spain follows similar trends.

Several, probably interconnected, explanations have been offered to account for this increase: 1) the visibility given to transgender issues in the media, 2) the internet, with its myriad sites on gender dysphoria, 3) the gradual depathologization and reduction of stigma regarding gender dysphoria and transgender identity, 4) the availability of biomedical treatment, beginning with the suppression of pubertal development, and 5) the “affirmative” approach to care adopted by many clinics and gender identity teams. Something is happening in childhood.

However, the truth is that this increase is due to an improvement in the care provided to a group that was very neglected. In the specific case of the United Kingdom, this is ratified by a report on this service (Tavistock and Portman NHS Foundation Trust, 2020) which states:

“The service was difficult to access. There were over 4,600 young people on the waiting list. Young people waited over two years for their first appointment”.

It is not only that referrals have increased, but also that the service was deficient for years and even today there are still thousands of young people on the waiting list who remain unattended. The reference that appears in the book on the situation in Sweden is not a scientific report but a news item in The Guardian of February 2020 (Orange, 2020) that exposes the controversy that arose from the broadcast of a television show where a report on trans people in Sweden was discussed. When we search and arrive at the report on which these news items are based, we read⁵:

In a first version of this press release, an incorrect figure per thousand was stated regarding what part of the population in 2018 had some form of gender dysphoria. This has been corrected [...] The increase seen over the past ten years applies primarily among children and young adults and especially among those who were registered as girls at birth. The number of new cases of diagnosed gender dysphoria among 13-17 year olds has increased by almost 1,500 percent since 2008 [...] Peter Salmi, a researcher at the [Swedish] National Board of Health and Welfare stated that, “Yes, there is no doubt that the increase is clear; however, we do not know what the increase is due to.”

The reality is that, as stated later in this report, after this 1,500% increase, the total number of diagnosed individuals in Sweden does not even reach 6,000, 0.6 per thousand of the population. In other words, it has taken a 1,500% increase in care for trans people for them to represent 0.6 per thousand of the population. This really paints a bleak picture of the care received by these people in the past. Regarding Spain, the article cited by Errasti and Perez (Becerra, 2020) states:

Some studies suggest that between 0.17 and 1.3% of adolescents and young adults identify as transgender, and this increase has been described by some as an “outbreak”⁶. [...] In Spain this phenomenon is also reaching similar dimensions and with similar explanations. The existence of Gender Identity Units (GIU) in the public health system in almost all the autonomous communities has significantly covered the health needs of the population. In addition, we must highlight the publication in the different autonomous communities of laws that have made it possible to stimulate both public health care and the achievement of personal and social rights.

Can 0.17% or 1.3% be considered an “outbreak”? To better understand the true dimension of the different prevalence figures mentioned, it must be said that we do not know exactly how many trans people there are in the world because the criteria for assessing this prevalence may change from one study to another (Collin et al., 2016). However, there is talk of figures around 0.9 in the USA (Meerwijk & Sevelius, 2017) and 1% in the UK (Glen & Hurrell, 2012; Reed et al., 2009). Some reviews even reach figures of 4.6% in Europe (Arcelus et al., 2015). Thus, 1% cannot be considered anything but “normal” in the strictest statistical sense. So, if, for example, the UK population is 67 million, 1% would be 670,000 trans people in the UK. The figure of 713 individuals/year mentioned in the book may be a low number, quite contrary to what the authors of the book under review suggest. The same can be said for the rest of the countries and figures.

Conclusion: the increase in the number of referrals is due to previous malfunctioning of the centers and insufficient care for trans people but not to any kind of fashion or prevailing ideology as suggested in the book.

The study by Dhejne et al. (2011)

When referring to the affirmative approach, the authors state the following (p. 327-330):

“Follow-up studies of transgender individuals who have undergone sex reassignment surgery unfortunately do not show the benefits with which the affirmative approach is presented. A 2011 follow-up study of more than 10 years—not cited in the APA report—indicates that “even if sex reassignment alleviates gender dysphoria, concurrent psychiatric morbidity needs to be identified and treated not only before, but also after reassignment”

The follow-up study they refer to is that of Dhejne et al (2011) which does not evaluate the efficacy of the affirmative psychological approach but that of reassignment surgeries as its title clearly indicates. Equating “affirmative approach” with

⁴ Note that the pagination corresponds to the electronic version of the book. This one, in particular, I read on the Nextory reading platform.

⁵ <https://www.socialstyrelsen.se/om-socialstyrelsen/pressrum/press/vanligt-med-flera-psykiatriska-diagnoser-hos-personer-med-konsdysfori/>

⁶ This report also discusses ROGD and other myths but puts the percentage of detransitioners between 1 and 8%.

"surgeries" is misleading as will be seen below, but let us not get ahead of ourselves. The referenced study concludes the following:

"Persons with transsexualism, after sex reassignment, have considerably higher risks for mortality, suicidal behavior, and psychiatric morbidity than the general population. Our findings suggest that sex reassignment, although alleviating gender dysphoria, may not suffice as treatment for transsexualism, and should inspire improved psychiatric and somatic care after sex reassignment for this patient group."

Dhejne and colleagues call for improved care for transgender people that is not limited to mere surgeries. These authors stress the need to create better psychological care to support trans people for longer and the need for a world with less transphobia. In this sense, it is important to remember that long-term studies include people who have undergone experimental surgeries that have not provided them with a better quality of life. The bottom line is that transgender people are such a vulnerable and victimized group that neither reassignment nor psychological support limited to the period of their transition is enough to solve their mental and emotional health problems. Many of them need psychological support for much longer, and the study by Dhejne et al. aims to emphasize this. If that is what Errasti and Perez intended to say, obviously one cannot disagree. The problem is that the book suggests that affirmative therapy is limited to promoting surgeries and fails to mention that affirmative psychology, exactly the opposite of what is indicated, advocates a much broader intervention than just surgery:

Psychologists are encouraged to inform public policy to reduce negative systemic impact on TGNC⁷ people and to promote positive social change. Psychologists are encouraged to identify and improve systems that permit violence; educational, employment, and housing discrimination; lack of access to health care; unequal access to other vital resources; and other instances of systemic inequity that TGNC people experience (APA, 2015).

Conclusion: precisely what affirmative therapy supports is that surgeries are not a panacea.

The mantra of 80% of detransitions

The authors state that the criteria for affirmative therapy are lax and that it is not supported by the evidence according to Cantor's review (p. 316-318):

Although the statements of the AAP and the psychological APA are supported by abundant scientific literature, more careful reviews of the available evidence show that the affirmative approach is not so evident, nor can other alternatives be ruled out. On the other hand, the psychiatric APA statement is a document of little more than one page, without references, in favor of affirmative treatment and emphatically opposing any attempt to impede access to such treatment. It is therefore appropriate to analyze the statements of the said academies of pediatrics and psychology.

7 TGNC: trans and gender non-conforming people.

The AAP Policy Statement in favor of the affirmative approach is not supported by the evidence according to James Cantor's review. The problems with this statement, according to Cantor, relate both to what it leaves out and to the partial interpretation of the sources it cites. It leaves out the numerous studies—at least eleven—follow-up studies of childhood and adolescent gender dysphoria, which invariably show that the majority of those who present with dysphoria desist, not to mention the growing number of detransitioners. This suggests two things: one is that the affirmative "sooner rather than later" approach may be hasty, and the other that watchful waiting would be more prudent.

The article by Cantor (2020), which, according to the authors, seems capable of dismantling the abundant evidence on which affirmative therapy rests, actually only refers to children and adolescents and is limited to asking about the persistence of the diagnosis of "gender dysphoria" past adolescence. In addition to the fact that there seems to be very little material to dismantle all the accumulated evidence in favor of the affirmative approach, there is something important to clarify about the "desisters" or "detransitioners" referred to in this study.

On the concept of "detransitioning" there has been much controversy to the point that the 80% to which I refer with the title of the epigraph has become a mantra repeated by conservative sectors about the percentage of minors who "desist" from feeling transgender. I will explain this in detail but, first, it is important to clarify that it is categorically false that the APA guidelines (APA, 2015) take transitions lightly. Quite the contrary, the guidelines, with regard to minors are very cautious, and please remember that our role is to accompany, not to prescribe medical treatments. In addition, they are very aware that gender nonconformity may be transitory. To say that the APA is very lax or that it encourages transitions is untruthful (APA, 2015):

"Because gender nonconformity may be transient for younger children in particular, the psychologist's role may be to help support children and their families through the process of exploration and self-identification (Ehrensaft, 2012). Additionally, psychologists may provide parents with information about possible long-term trajectories children may take in regard to their gender identity, along with the available medical interventions for adolescents whose TGNC identification persists (Edwards-Leeper & Spack, 2012)."

Returning to detransitioners, another article similar to the one cited by Errasti and Perez (Kaltiala et al., 2018) states that 80% of minors desist from their transsexuality:

"Evidence from the 10 available prospective follow-up studies from childhood to adolescence (reviewed in the study by Ristori and Steensma) indicates that for ~80% of children who meet the criteria for CDG, the GD⁸ recedes with puberty. Instead, many of these adolescents will identify as non-heterosexual".

Let us follow the thread, starting by turning to the original article cited, that of Ristori and Steensma (2016) where we find:

"The conclusion from these studies is that childhood GD is strongly associated with a lesbian, gay, or bisexual outcome

8 "Criteria for gender dysphoria" and "gender dysphoria" respectively.

and that for the majority of the children (85.2%; 270 out of 317) the gender dysphoric feelings remitted around or after puberty (see Table 1).”

In this article, the author expresses a reasonable doubt about the persistence of GD⁹ once these children become adults and about the appropriateness of applying irreversible treatments. This same caution is expressed in other recent articles (Singh et al., 2021) which, incidentally, also recognizes methodological flaws in the studies that talk about detransitions:

“In recent years, there have been various criticisms of these follow-up studies (Rafferty, 2018; Winters, 2019); for a rebuttal, see Zucker, 2018 particularly with regard to the putatively high percentage of desistance. It has been questioned, for example, to what extent the patients in these studies truly had GID/GD. For example, in the early studies, prior to the publication of DSM-III, one could reasonably argue that the diagnostic status of the patients was unclear because there were no formal diagnostic criteria to rely upon. However, one could argue in return that the behavior of these boys was phenomenologically consistent with the subsequent DSM criteria”.

With the clarification of the diagnostic criteria, many of those who were previously included in the sample are no longer considered to have gender dysphoria. They have not been “cured” or “given up” but had previously been erroneously considered “dysphoric.” Even so, however, there does exist a percentage of “detransitioners,” but more recent publications deny that they are such a large group. For example, Winters (Op. Cit.) states:

“The most pervasive and damaging stereotype about transgender children that is used to frighten parents, therapists, and medical professionals is that the vast majority of them are “going through a phase.” The “80% desistance” dictum alleges that gender dysphoria, defined as distress with their physical sex characteristics or associated social roles, and identification as trans will remit for approximately 80% of young trans children. It predicts that most young trans boys will spontaneously revert to identifying as girls by puberty and develop into cisgender lesbian women, and that most young trans girls will spontaneously revert to identifying as boys by puberty and develop into cisgender gay men. A growing body of research is focused on transgender children with supportive families and care providers and is refuting the stereotype that most trans or gender dysphoric children are “confused” and will become cisgender gay or lesbian adults. Socially transitioned trans children supported by their families exhibit far less psychopathology than previously reported among closeted and unsupported youth. Prospective studies in progress will no doubt shed much more light on the outcomes of trans children who are supported in socially authentic gender roles”.

It seems that, in any case, a percentage (smaller, as we shall see) desists due to the pressures of their family and social environments, since this “turning back” does not occur in adolescents who have family support. In the same direction we find the contributions of Ashley, F. (2021) who, in her abstract explains:

“In recent years, the suggestion that over 80% of trans and gender creative children will grow up cisgender has been strongly criticized in the academic literature. Although concerns over the methodology of these studies, known as desistance research, has shed considerable doubt regarding the validity of the reported number, less attention has been paid to the relevance of desistance research to the choice of clinical model of care. This article analyzes desistance research and concludes that the body of research is not relevant when deciding between models of care. Three arguments undermining the relevance of desistance research are presented. Drawing on a variety of concerns, the article highlights that “desistance” does not provide reasons against prepubertal social transition or peripubertal medical transition, that transition for “desisters” is not comparably harmful to delays for trans youth, and that the wait-and-see and corrective models of care are harmful to youth who will grow up cis. The assumed relevance of desistance research to trans youth care is therefore misconceived. Thinking critically about the relationship between research observations and clinical models of care is essential to progress in trans health care”.

As can be seen, the damage of not being able to transition is more irreparable. However, Errasti and Pérez insist strongly on the danger of the affirmative approach and on the risk posed by detransitions (p. 330-332):

Detransition is an emerging phenomenon that highlights two things: the after-effects of the affirmative approach and the added problems of dealing with one’s own detransition, including feelings of regret, abandonment, loneliness, shame, and the physical and social changes undertaken. Although the prevalence of detransition is unknown, it is probably underestimated. What is certain is that there is no single narrative to explain the experiences of all those who undertake it. Some detransitioners re-identify with their birth sex, others assume (or maintain) a non-binary identification, and some continue to identify as transgender. Likewise, some detransitioners regret having transitioned and others do not. Still others report experiences that support the rapid-onset dysphoria hypothesis that their gender dysphoria began during or after puberty and that mental health issues, trauma, peers, social networks, online communities, and difficulties accepting themselves as lesbian, gay, or bisexual were related to their gender dysphoria and desire to transition.

This collection of inaccuracies requires a long exposition that begins by explaining the Vandebussche (2022) study, the first reference in the paragraph. This study takes its sample from an online survey realized through platforms aimed at people who have “detransitioned”:

“A cross-sectional survey was conducted, using online social media to recruit detransitioners. Access to the questionnaire was open from the 16th of November until the 22nd of December 2019. Any detransitioner of any age or nationality was invited to take part in the study. The survey was shared by Post Trans (www.post-trans.com)—a platform for female detransitioners—via public posts on Facebook, Instagram, and Twitter. Participants were also recruited through private

⁹ Gender dysphoria (GD). Many of these authors use this nomenclature, nowadays in disuse and not recommended by affirmative psychology.

Facebook groups and a Reddit forum for detransitioners (r/detrans). Some of the latter platforms were addressed exclusively to female detransitioners”.

Frankly, with this recruitment method, it is surprising that only 50% of the population claims to have detransitioned. But, in addition to the questionable selection of the sample of this study, the very definition of “detransitioner” is confusing and this is not a minor problem since it is the main variable of the study:

“The term “detransitioner” will be used here to refer to someone who possibly underwent some of these medical and/or social detransition steps and, more importantly, who identifies as a detransitioner. It is important to add this dimension, because the act of medical/social detransition can be performed by individuals who did not cease to identify as transgender and who do not identify as detransitioners or as members of the detrans community. Furthermore, some individuals might identify as detransitioners after having ceased to identify as trans, while not being in a position to medically or socially detransition due to medical or social concerns. As Hildebrand-Chupp (2020) puts it: “[B]ecoming a detransitioner involves a fundamental shift in one’s subjective understanding of oneself, an understanding that is constructed within these communities” (p.802). More qualitative research should be conducted in order to better understand how members of the detrans community define themselves and make sense of their own detransition process. However, this goes beyond the scope of this study”.

How is it possible that some people can identify as detransitioners while still identifying as transgender? I find it striking that Errasti and Pérez strongly criticize in other chapters that a person asks to be recognized as “what they feel” even though this intimate identification is not manifested in their gender expression and, at the same time, they rely on a study where the participants are people who want to be recognized as something they do not express externally and whose author states that “becoming a detransitioner implies a fundamental change in the subjective understanding of oneself”. This contradicts the theses that Errasti and Perez argue in the chapters on queer thought but, as I said, those chapters are not the object of my analysis. It only seemed appropriate to highlight this impressive ceremony of confusion. In any case, I insist: if a study does not define its variables well, the conclusions it reaches cannot be taken too seriously. And this is what happens with [Vandenbussche’s work \(2022\)](#) which, by the way, adds even more confusion by reporting the reasons for detransitioning adduced by the participants in its sample:

“The most common reported reason for transitioning was realized that my gender dysphoria was related to other issues (70%). The second one was health concerns (62%), followed by transition did not help my dysphoria (50%), found alternatives to deal with my dysphoria (45%), unhappy with the social changes (44%), and change in political views (43%). At the very bottom of the list are: lack of support from social surroundings (13%), financial concerns (12%) and discrimination (10%). 34 participants (14%) added a variety of other reasons such as absence or desistance of gender dysphoria, fear of surgery, mental

health concerns related to treatment, shift in gender identity, lack of medical support, dangerousness (sic) of being trans, acceptance of homosexuality and gender non-conformity, realization of being pressured to transition by social surroundings, fear of surgery complications, worsening of gender dysphoria, discovery of radical feminism, changes in religious beliefs, need to reassess one’s decision to transition, and realization of the impossibility of changing sex”.

We see that the major reason for detransitioning was “my gender dysphoria was related to other issues,” but it does not specify what those issues were. Moreover, it does not deny the persistence of dysphoria, it only states that medical transition was not a panacea (something we have already discussed). Only in the 14% “mixed bag” is it mentioned that the reason was that gender dysphoria had disappeared.

Having analyzed this study and its methodological problems, we must ask ourselves: is it true what they say about the percentage of “detransitioners”? The evidence says it is not. In an article with a Spanish population ([Pazos Guerra et al., 2020](#)) there are 8 detransitions out of 796 cases attended, which means 1% of the total. In the US population ([Turban et al., 2021](#)¹⁰) the following results are given:

“A total of 17,151 (61.9%) participants reported that they had ever pursued gender affirmation, broadly defined. Of these, 2,242 (13.1%) reported a history of detransition. Of those who had detransitioned, 82.5% reported at least one external driving factor. Frequently endorsed external factors included pressure from family and societal stigma. History of detransition was associated with male sex assigned at birth, nonbinary gender identity, bisexual sexual orientation, and having a family unsupportive of one’s gender identity. A total of 15.9% of respondents reported at least one internal driving factor, including fluctuations in or uncertainty regarding gender identity”. The transitions reported had to do with lack of family support or discovering they were non-binary.

The preprint of the most up-to-date follow-up on trans minors has recently been published ([Olson et al., 2022](#)) and its conclusions are clear:

“These results suggest that detransitions are infrequent. More commonly, transgender youth who socially transitioned at early ages continued to identify that way. Nonetheless, understanding retractions is crucial for clinicians and families to help make them as smooth as possible for youth.”

Conclusion: if there are transitions: (1) they occur in a much lower percentage than the authors of the book claim and (2) most of these transitions are related not to the fact that people are not trans, but to other factors such as the fact that they are non-binary people, a lack of family support, or social discrimination. The problem is transphobia, not the affirmative approach.

About affirmative therapy

In addition to the above, the authors of the book sow doubts about affirmative therapy in other places in their book such as (p. 316-318):

¹⁰ Incidentally, Cantor complained that Turban had not replied to his article. It seems that Turban did reply to him but through this publication.

The affirmative approach, however well-intentioned, is not without its problems. For one thing, not all cases are equal enough to offer a “one-size-fits-all” approach. For another, it can cause irreversible damage for those who want to go back, a phenomenon that is becoming increasingly common. Finally, it does not solve all problems, even for those for whom it is the most appropriate option. In reality, the affirmative approach is more politically correct than scientifically correct.

To illustrate their assertion on “one size fits all”, they cite D’Angelo et al. (2021). For the second assertion (the “irreversible damage”) they rely on a controversial book accused of the same misrepresentations and errors that we are analyzing here and also published by the same publisher (Shrier, 2021). The citation of their third statement is the study by Dhejne et al. of which we have already spoken and about which it is not worth repeating that its authors do not intend to say what Perez and Errasti have interpreted. Let us analyze, therefore, D’Angelo’s article, where it is stated that:

We believe that exploratory psychotherapy that is neither “affirmation” nor “conversion” should be the first-line treatment for all young people with GD, potentially reducing the need for invasive and irreversible medical procedures. This is especially critical now, when we are witnessing an exponential rise in the incidence of young people with GD who have diverse and complex mental health presentations and require careful assessment and treatment planning.

It would seem that the affirmative approach, as described by Errasti and Perez, has no other purpose than to send trans people, whatever their age, to reassignment processes without further consideration. And it would also seem that the authors have not read the APA guidelines for trans people, regardless of the frequency with which they mention them. I say this because from the very first guideline they completely shy away from the “one-size-fits-all model” with which these authors try to caricature the affirmative approach:

*Largely because of self-advocacy of TGNC individuals and communities in the 1990s, combined with advances in research and models of trans-affirmative care, there is greater recognition and acknowledgment of a spectrum of gender diversity and **corresponding individualized, TGNC-specific health care** (boldface is mine).*

In speaking of affirmative therapy and its alternatives (“watchful waiting” and “psychotherapeutic exploration”), the truth is also lacking (p. 408-410):

As opposed to the affirmative approach consisting of acceptance and affirmation of the gender identity expressed by the child and adolescent, in order to accompany and advise the transition process without further consideration, it has been documented that it does not have the evidence it is supposed to have to improve the psychological problems for those for which it is adopted. We have also shown the tendentious strategy of labeling as “conversion therapy” anything other than adherence to the affirmative approach. Statements of adherence to the affirmative approach made by professional and scientific societies are made on ideological motivations, not on properly scientific grounds.

Thus, for example, the American Psychological Association, as well as the American Psychiatric Association, overlook a great deal of knowledge and procedures in their own disciplines that would discourage the affirmative approach as the only acceptable approach, without implying its exclusion. Alternatives to the affirmative approach such as watchful waiting, psychotherapeutic exploration, and psychological assessment may be desirable in many cases, and would be a better starting point than the “one size fits all” of affirmation. In the end, the affirmative approach itself reveals itself as a “conversion therapy,” committed from the outset to irreversible transitions.

It is not true that “watchful waiting” or exploration are alternatives to affirmative therapy because the latter also includes them. Errasti and Perez identify affirmative therapy with a procedure where the person, no matter what, will be led to transition and this is not true either. The person will be accompanied in his or her transition without making him or her go through tests such as the “real life test” (typical of approaches to transsexuality prior to transaffirmative psychology), only when the person is clear about his or her identity. If a person has doubts, no psychology professional will try to convince them that they are trans, but rather accompany them for as long as it takes for them to explore their identity and resolve their doubts. This is also an “attentive waiting” and a respectful and humane treatment. In contrast to previous approaches, affirmative practitioners start from the recognition that we do not know what the person is or needs any better than the person him- or herself. In colloquial terms, “*we don’t give anyone a trans ID card*”. Thus, in the guidelines we can find advice such as the following:

*A nonjudgmental stance toward gender nonconformity can help to counteract the pervasive stigma faced by many TGNC people and **provide a safe environment to explore gender identity and make informed decisions about gender expression** (boldface is mine).*

Final conclusion

As affirmative psychology professionals, we must avoid biased interpretations of scientific studies, especially those likely to fuel prejudice against any minority. On this point APA guideline number 21 (APA, 2022¹¹) expressly warns:

“In the use and dissemination of research on sexual orientation and related issues, psychologists strive to represent results fully and accurately and to be mindful of the potential misuse or misrepresentation of research findings.”

Just as guideline number 15 does the same in relation to research with trans people (APA, 2015):

“Psychologists respect the welfare and rights of TGNC participants in research and strive to represent results accurately and avoid misuse or misrepresentation of findings.”

It is understandable that people without criteria might fall into the trap of believing what a “scientific study” says without being

¹¹ The APA has published two collections of guidelines. On the one hand, those specific to lesbian, gay and bisexual people, the latest revision of which was published in 2022 and, on the other hand, those specific to trans people, published in 2015.

able to analyze the defects of its methodology to realize that this study has little scientific value. But we, if we are proponents of evidence-based psychology, cannot fall into this type of error. Much less if we intend to carry the responsibility of dissemination on our shoulders. Thus, our job is to offer truthful information, based on evidence, and arising from rigorous studies. We cannot disseminate content that has been refuted or whose methodologies are flawed. The chapters of "No one is born in the wrong body" dedicated to the affirmative approach are riddled with falsehoods, studies that have been refuted, and misrepresentations of the conclusions of other research. This is not admissible. When a book is intended to open a debate on any topic, it is expected that the book will include all the research that has been done on the subject and, if it is intended to illustrate a controversy, it is also expected to include all the contributions that make up that controversy. In the case of "rapid onset gender dysphoria," this book only includes the part in which the existence of this phenomenon has been given credence but has not presented either the criticisms that the concept has received or its subsequent refutations. Something similar can be said about the reports on "detransitioners": the data collected are strongly biased towards the presentation of the phenomenon as if it were a major problem when the reality is that it is a marginal phenomenon and can be explained either by family pressures or by the discovery that they were non-binary people. Nor does it explain that, while there may certainly be some people who have been hasty in their decisions, limiting the transition process can be tremendously detrimental to the very many people who do maintain their gender identity into adulthood. Similarly, the affirmative approach cannot be blamed for laxity when the guidelines insist on caution in dealing with minors and on creating safe spaces for reflection. The latter also does not appear in the book under review.

The authors of an essay that addresses any topic are obliged to document and explain it in depth. Failure to do so, in this particular case, may give rise to distorted and negative views of both the affirmative approach as well as trans people and their pro-equality organizations, since it would appear that they promote abject ends, which is not true. Scientists also have a social responsibility.

Conflict of interest

The author declares that there is no potential conflict of interest related to the article.

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