The role of social work and social welfare in the current crisis facing trans youth in the US

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Social work in the US has failed to respond to the largest legislative attack on the rights of transgender and non-binary people in the history of the country. Hundreds of laws have been proposed over the past several years, aiming to ban transgender and non-binary people from public life, as well as criminalising gender-affirming healthcare and attempting to remove transgender youth from supportive families for forced detransition. Beginning with the Trump administration, these bills have exponentially increased in number, now being proposed in more than 60 per cent of the US. This article critically reviews the ways in which national social work organisations have failed to address both the systemic erasure of transgender people in their pedagogy and the behaviours of specific actors within the social work profession who are actively helping to draft anti-trans legislation and advocate for conversion therapy, contravening both the evidence base and code of ethics.

Key words transgender • lesbian, gay, bisexual, transgender and queer (LGBTQ rights) • United States legislation • human rights • conversion therapy

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Introduction

By the summer of 2022, hundreds of potential laws targeting the lesbian, gay, bisexual, transgender and queer (LGBTQ) community had been introduced around the US, over 150 of which aimed to roll back existing protections, rights and healthcare for transgender youth and adults. Thus, in the first six months of 2022, more anti-LGBTQ laws were proposed than in all of 2021, during which at least another 150 bills were proposed in 22 states. Many bills sought to limit access to the evidence-based healthcare that is recommended for transgender youth, and some carried criminal penalties for providers and/or parents (Movement Advancement Project, 2021). The widespread attack on transgender rights draws support from far-right institutions like the Heritage Foundation and the Alliance Defending Freedom, and
many bills raise questions about child protection that drive through the heart of every major human rights framework. Despite the silence of bedrock institutions within the social work profession, this is an issue at the core of social work. This attack affects transgender individuals, allies and professionals in a multitude of fields, with ramifications for every social worker practising in the US, as the impacts of these bills spread well beyond the jurisdictions in which they have been proposed.

The current crisis

On 23 February 2022, Texas Governor Greg Abbott, in conjunction with the Texas Office of the Attorney General, announced that he would be instructing the Texas Department of Family and Protective Services (DFPS) to begin investigating the families of transgender youth accessing gender-affirming medical care (Goodman and Morris, 2022). Within 48 hours, the state child protection agency had opened its first investigation – against a staff member with a transgender daughter who had spoken to her supervisor about her fear that her family would be targeted by the executive order (Asgarian, 2022). She was subsequently suspended, and a colleague from her own workplace came to her home to begin an investigation. While her family successfully sought an injunction, hers and a handful of plaintiffs from the lawsuit were the only families granted temporary relief under the initial ruling. Additional families continued to be contacted and investigated by actors from within the field of child protection, and although a permanent injunction is now in place, the Texas government is appealing that ruling. In addition to the effects on individual families, the order has had a systemic impact on the availability of evidence-based gender-affirming care in the state. After threats of indictment reached leadership at Texas Children’s Hospital, their clinic, the largest provider of gender-affirming care in the state, announced an indefinite halt to care for transgender youth (Branigin, 2022).

This is part of a larger campaign attacking transgender rights that originated during the Trump administration, resulting in an exponential increase in the number of proposed anti-transgender bills. Of the bills introduced in 2021, 67 were specifically aimed at transgender youth and 34 attempted to ban lifesaving medical care. While initially focused on restricting access to puberty blockers, the aims of the healthcare-focused bills expanded rapidly. Senate Bill 23 (Hall, 2021), introduced in August 2021 by Texas state Senator Bob Hall, included a provision that explicitly banned any gender-affirming care for youth. The proposed bill included the following text:

A mental health provider may not provide gender-affirming therapy or counseling to a child to treat gender dysphoria if the purpose of the therapy or counseling is to affirm a gender that is inconsistent with the child’s biological sex. (Hall, 2021)

This and similar bills would redefine the affirmation of transgender youth in any form by any person above the age of majority, including parents and teachers, as abusive. It also recommended incarceration for providers engaged in gender-affirming care. The most extreme version of this recommendation is an Idaho bill proposing life in prison for gender-affirming surgery providers (Factora, 2022; House State Affairs Committee, 2022). Proponents of these bills cite the threat of gender-affirming surgery
on children, despite the facts that gender-affirming surgeries are not performed on children and only rarely on adolescents. Ironically, many bills that eliminate access to transgender care explicitly exclude, and, by doing so, endorse, genital surgeries performed on intersex infants (Developments in the Law, 2021).

The 2022 legislative session has seen an escalation in anti-transgender legislation, including bills advocating for healthcare restrictions, seeking to ban students from participating in athletics in accordance with their gender, preventing trans students from accessing bathrooms and changing facilities, and even protecting teachers who misgender children. Other bills seek to ban transgender people from altering birth certificates and obtaining correct gender markers on state identification, as well as to roll back the already-flimsy protections afforded to transgender prisoners. A spate of bills also seek to prevent even the discussion of gender or gender identity in school curricula, making it a crime for schools to mention gender identity without also teaching about detransition and transition regret. As of this writing, Florida has already passed HB 1557 (Harding, 2022), dubbed the ‘Don’t Say Gay [or trans] Bill’ by the US news media, which prohibits discussion about sexual orientation and gender identity in kindergarten through Grade 3 or in any way that is not age or developmentally appropriate ‘in accordance with state standards’.

A bill in South Carolina seeks to establish a hotline through the state Attorney General’s Office for parents to report any mention of gender or sexual orientation to the state (Bennett et al, 2022). Such legislation as Mississippi’s SB 2111 would require any government worker (such as teachers or social workers) to report suspected gender-nonconformity to parents in writing, and would make it a crime for schools to knowingly withhold information about a student who is questioning their gender (Burks Hill, 2022). These bills would seek to overturn policies put into place after students have been kicked out of their homes or had faced violence from their parents after schools disclosed their sexual orientation and/or gender identity (Snapp et al, 2015).

Despite multiple protests and statements about various proposed pieces of anti-trans legislation from various professional organisations, as well as statements about the need to not ‘practice, condone, facilitate, or collaborate with any form of discrimination on the basis of … gender identity’ in the code of ethics, the National Association of Social Workers (NASW) has repeatedly failed to take a public position against any proposed anti-transgender legislation (American Medical Association, 2021; American Psychiatric Association, 2021; American Psychological Association, 2021). This was particularly concerning for bills that characterised gender affirmation as child abuse, as social workers represent the largest group of providers responsible for carrying out both the associated mandated reporting tasks and the majority of gender-affirming mental healthcare described therein. It was only after 140 other organisations drafted an open letter in defence of gender-affirming care that the NASW offered itself as a co-signer (Coalition for the Advancement & Application of Psychological Science, 2021). Outside of this singular statement, the NASW has remained largely silent, only speaking up once during Ken Paxton’s proclamation that trans children should be separated from their families and forcefully detransitioned, with parents and providers prosecuted for felony child abuse (National Association of Social Workers, 2022). The failure of the social work profession to respond to the growing crisis is consistent with a social work pedagogy in which transgender and non-binary people are largely absent.
Statement of positionality

Given the growing awareness of the relevance of our intersecting identities in the conceptualisation, delivery and evaluation of social and mental health services, the authors wish to make this statement about their own respective identities. Both authors are white, bisexual and culturally Jewish. The first author is a clinical social worker and transgender woman who currently works full-time in transgender health. The second author is a cisgender woman, clinical social worker and researcher who also works full time in transgender health.

The roles of social workers in gender care in the US

In the US, social workers fulfil a variety of professional roles, depending on training and licensure. While baccalaureate social workers make up the majority of child protection workers, case managers and advocates, master’s and doctorate-level social workers primarily provide clinical care in the form of assessment, crisis intervention, psychotherapy and group work. Social workers of all training levels often work in medical settings and schools, performing tasks varying from developmental and psychological assessments, to violence prevention, as well as reintegration from carceral or involuntary congregate care settings (for example, state psychiatric hospitals and court-mandated chemical-dependency treatment centres).

US-based social work has long struggled with an artificial distinction between clinical (therapeutic) and macro (policy-based) social workers. Many social work educators suggest that this makes US clinical social workers less prepared for contextualising the role of larger policy decisions and structural/institutional barriers in the problems facing those who access our services (Belkin Martinez and Fleck-Henderson, 2014). In addition, many case-management roles span both clinical and macro practice, requiring an understanding of both individual concerns and the socio-political environment.

Transgender people may be part of the population receiving any type of social work service. In addition, social workers may perform transgender-specific services, including those assessments used to determine the appropriateness of hormonal or surgical interventions. Social workers might also facilitate family-therapy discussions in families where a member has come out, or work to inform how and when schools respond to transgender youth and in cases of anti-trans violence. At the policy level, social workers theoretically have an ethical obligation to speak out for marginalised populations in matters of criminal justice, medicine and agency/state policy as part of their work.

The lack of a nationalised healthcare system also means that US social workers are frequently called upon to help uninsured people access health insurance, as well as to advocate when commercial insurance providers deny coverage of medically necessary care – which includes gender-affirming care (Almazan et al, 2020). Meanwhile, the lack of federally enforced employment and healthcare protections for transgender people means that social workers at all levels may also be called upon to respond to cases where someone has been fired or denied housing due to their gender identity or expression. While individual states may have formal anti-discrimination laws, there is no national law preventing the firing of transgender people due to gender identity.¹ These concerns, therefore, are common (James et al, 2016).
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Pedagogical limitations in US social work training

The ability of social workers to effectively serve and advocate for their transgender clients, as well as the broader transgender population, is limited by deficits in current education and professional guidance. Despite calls for gender-identity cultural competence in the NASW code of ethics, social work training in the US does not currently effectively prepare social workers to work with gender-diverse people. The Council on Social Work Education (CSWE) currently makes no requirement at all that students learn about transgender and non-binary people in order to complete a graduate degree in social work (Austin et al, 2019; Timbers, 2020).

A review of the literature found that most social work schools have little or no education about gender-diverse people, with one study reporting that 85 per cent of respondents reported that transgender people were discussed ‘rarely’ or ‘never’ (Austin et al, 2019), while another found that only 35 per cent of respondents in US-based schools of social work reported having textbooks that even mentioned transgender people (Erich et al, cited in Austin et al, 2016). In addition to the lack of education on issues affecting transgender people, the research literature has also found that transgender and gender-diverse social work students are often let down by their schools. Studies have found that these students are repeatedly misgendered, deadnamed and ‘corrected’ about their own experiences of gender, and that gender-based oppression outside of the construct of binary assigned sex is rarely discussed (Austin et al, 2016; 2019).

Non-secular social work education in the US

The field of social work in the US has long operated on the same ahistorical presumption as the field of psychiatry, namely, that transgender people are defined by pathology, rather than that they are whole people within the broader community who could benefit from cultural brokerage. This may, in part, reflect that in the US, the field of social work originated out of the charity care movement and, since its inception, has been dominated by majoritarian, religious interests seeking to do mission work with marginalised families. While the field broadened in focus during the second half of the 20th century, religious social work programmes remain a large force within social work education. At present, the CSWE, which sets the standards for accreditation for schools of social work in the US, makes no specific allowances or requirements for religious institutions to teach secular curricula.

The proportion of baccalaureate social work programmes in the US that are housed within Christian and Mormon colleges, which explicitly bar the acceptance of transgender students and treat homosexuality as a subject of debate, raises an additional challenge for those entering the field (de Jong, 2015; 2017). While some Christian social work faculty have called for acceptance of transgender clients, this has generally prompted a harsh response from detractors set on maintaining the anti-transgender attitudes of many non-secular schools of social work (Hodge, 2003; Adams, 2017). Social work schools that provide graduate education may also exist within Christian institutions that have explicit or implicit anti-transgender policies.

The location of social work training programmes in institutions that deny the rights of transgender individuals and the legitimacy of transgender identities
supports the continuation of policies and practices that actively put transgender individuals at risk. During the 1990s, a group of religiously motivated practitioners founded what was then called the National Association of Research and Therapy of Homosexuality (NARTH). As the secular field moved away from attempting to ‘treat’ (that is, eliminate) homosexuality and gender expansiveness, and towards affirmation of sexual- and gender-minority individuals, NARTH provided a platform for homophobic practitioners to launch what is known as the ‘ex-gay’ movement and promoted the idea that mental health practitioners had a responsibility to help those with ‘unwanted’ same-sex attraction. This concept was formally enshrined by the field of psychology in the diagnosis of ‘ego-dystonic homosexuality’, which was added to the Diagnostic and Statistical Manual (DSM) III after pressure from gay-liberation activists led to the removal of homosexuality as a diagnostic category (Drescher, 2015).

Upon rebranding as the Alliance for Therapeutic Choice and Scientific Integrity (ATCSI), NARTH broadened its focus in the gender wars. One of the critical figures in this pivot is current ATCSI/NARTH President Shirley Cox. A professor at the Brigham Young University School of Social Work, the largest non-secular school of social work in the country, she co-wrote the 2009 manual on homosexuality for the Church of Latter-day Saints. Cox is credited as one of the architects of Utah House Bill 92, introduced during the 2021 legislative session (Rex and Bramble, 2021), which would seek felony indictments for providers engaged in gender-affirming care. Cox was joined in providing evidence in favour of that bill by current NARTH/ATCSI board members Sheri Golden, Geoffry Heath and fellow social worker Phillip Sutton.

Another critical figure is James Phelan, an adjunct professor of social work at Liberty University, who received grant money from NARTH in 2007 and helped write NARTH’s response to the American Psychological Association’s call for a permanent moratorium on conversion therapy alongside the far-right American College of Pediatricians. Phelan continues to find outlets to speak and proselytise for conversion therapy – including at the Association of Christians in Health and Human Services in July 2021, where Phelan serves as board secretary (Association of Christians in Health and Human Services, 2021). This and other similar appearances have been used to create the impression of an evidence base to support conversion-therapy practices, and events are often held at Christian institutions, including the Indiana Wesleyan University (IWU) School of Social Work. IWU is a private Christian university known for its vitriolic stance on LGBT rights, and the school prohibited lesbian, gay, bisexual and transgender students from being out on campus in their student handbook until as recently as 2018 (Indiana Wesleyan University, 2016).

Construction of transgender identities as a problem for the cisnormative family

Social work has long struggled with how to define the experiences of transgender people, largely ignoring the existence of gender expansiveness until the turn of the century. At that point, a handful of phenomenological studies began to look at the experiences of cisgender family members of transgender youth, but not at the experiences of the youth themselves (Ellis and Erikson, 2002; Zamboni, 2006). These
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studies routinely described experiences of loss during which caregivers mourned living family members. Frameworks generated out of these studies were created from the vantage point that transition represented a unique trauma for those in relationship to transgender people (Ellis and Erikson, 2002). Theorists at the end of the 20th century modified Elizabeth Kubler-Ross’s stages of grief for family members of transgender youth (Kubler-Ross, cited in Zamboni, 2006), while the transgender youth in question was relegated to a lifetime of isolation and ostracisation (Emerson and Rosenfeld, 1996; Lesser, 1999; Mallon and DeCrescenzo, 2006; Zamboni, 2006). Critics suggest that these models reify the idea for parents that there are two distinct children: the family member before transition and the family member after transition (Giammattei, 2015).

The positioning of gender transition in this divided manner eventually led to the development of models based on the ‘ambiguous loss’ framework (McGuire et al, 2016; Testoni and Pinducciu, 2019). Early iterations of this framework encouraged social workers to facilitate sessions during which caregivers were given space to speak about the dreams they had for their children. The sense of loss was compounded, authors suggested, by the potentiality for families to themselves become isolated within their own communities as others questioned their competence as parents (Israel and Tarver, 1999; Lesser, 1999; Mallon and DeCrescenzo, 2006; Dierckx et al, 2016).

While little guidance was offered for the official position of the therapist on the validity of diverse gender identities, taken for granted was the notion that having a gender-diverse child was a problem to be solved (von Doussa et al, 2020). Social workers were encouraged to see transition as a goal held within the family system, with no one family member holding a more important role in the self-determination of the system (Vanderburgh, 2009). This professional emphasis on the experience of everyone in the family, rather than a centring of their transgender experience, meant that the dominant modes of understanding trans people were generated by cisgender providers and based on cisgender family members, sometimes to the exclusion of the transgender people themselves. This discursive decentring of transgender voices replicated a tendency of human service providers to perpetuate dominant ideas, rather than hold up the voices of those most marginalised.

Family identity models directed at families of transgender youth replicate two critical problems with transgender care as it exists today. By failing to address the changing nature of gender throughout the life cycle, providers reinforce the idea that there is a normative experience of transition – norms that have historically been established by everyone but transgender people themselves (Kennedy, 2022). This failure also provides room for social workers and mental health providers who have little experience with gender-diverse people to mistake the natural progression of an individual’s gender identity through the exploration of new modes of self-expression and self-identification as being somehow evidentiary that a given service user’s identity is less legitimate or merely transitory (Malpas, 2011). It also imputes pathology and regret to all instances where a gender-diverse person’s identity evolves to a cisgender identity, sometimes referred to as ‘detransition’ (Hildebrand-Chupp, 2020).

Until quite recently, social work practice with transgender persons was centred on a cis-centric epistemology, whereby the intersubjective experiences of gender-variant people were understood exclusively through the eyes of cisgender providers – predominately through the inherently pathologising lens of psychiatry. In her historiography of subjugated narratives of trans children through the early 20th
century, Jules Gill-Peterson argues that the rush to medicalise understandings of trans experience may have come at the expense of an epistemology that would allow for trans self-knowledge to form the basis of medicine’s understanding of trans bodies, rather than the other way around (Gill-Peterson, 2018). Although the framing of gender dysphoria as a pathologic condition that requires treatment has encouraged the recognition of medical and surgical gender affirmation as medically necessary, it inherently problematises transgender bodies in ways that are not necessarily an expression of all transgender people’s experience (Gill-Peterson, 2018: 15).

Social work ‘safeguarding’ and the fear of transgender parents

It is not just transgender children who are misrepresented by the social work family literature and practice, but also transgender parents. Within the child protection and safeguarding literature, social workers have for decades written about the need to thoroughly monitor the children of transgender parents for any signs of danger (White and Ettner, 2007). Social workers working in these areas have historically seen any mental health challenges present in children of a transgender parent as evidence that trans parenthood is harmful to children, much as social work and psychology had previously done with children of lesbian, gay and bisexual parents (Freedman and Tasker, 2002).

As of 2017, no federal protections existed for transgender parents in child custody or child protection matters, allowing courts to make discretionary decisions about whether having a transgender parent is against the best interests of the child (Perez, 2010; Cohen, 2017). As a result, transgender parents have had their children taken away after transition (Cohen, 2017). Transgender parents also frequently endure unending misgendering and deadnaming from judges during custody proceedings (Perez, 2010). The intrinsic power imbalance between the judge and a defendant or plaintiff in court requires that transgender parents endure this humiliation, lest any protest to the contrary be used to justify an unfavourable judgment (Cohen, 2017).

‘Rapid onset gender dysphoria’ and the campaign against gender-affirming care

Testimony supporting limiting access to gender-affirming care cites a small, and formerly relatively obscure, body of mental health literature published between 2016 and 2020 that posited a ‘psychic epidemic’ affecting US youth, inducing ‘sudden and unforeseen gender dysphoria’ – the clinical term used to describe the discomfort that many transgender/non-binary people experience as a result of the disjunction between their gender identity and their sex assigned at birth. The article upon which this was based was written by Lisa Marchiano (2017), a US-based social worker and self-described Jungian psychoanalyst. A second article used to support this analysis, describing a concept the author referred to as ‘rapid onset gender dysphoria’ (ROGD), has been repeatedly criticised for biased methodology and other concerns (Littman, 2018; Restar, 2020).

While Marchiano’s writing represented a substantial departure from the empirical evidence about gender identity development and treatment, she nevertheless continued a long tradition within social work of seeing transgender people as both less capable of making treatment decisions about their own well-being and less deserving of
autonomy than their cisgender peers. Littman’s follow-up similarly positioned the parents of transgender youth as the experts in their lives, rather than the youth themselves – something that opposes one of the fundamental precepts of social work practice. The ideas underpinning the current wave of anti-transgender legislation are fuelled by social work’s fundamental refusal to take a position against the outdated and harmful practice models embodied by the psychoanalytic movement of the 20th century. They go beyond the gatekeeping, infantilising practices experienced by transgender people seeking medical care prior to the adoption of the informed consent model and seek to eliminate some individuals’ access to care altogether. Even where legislation is not passed, or where it is overturned, the presence of these ideas in widespread public discourse has the potential to increase stigma and both directly and indirectly affect the well-being of transgender individuals.

Interest in and acceptance of the idea that social contagion plays a role in gender-identity development appears to be, at least in part, a response to the documented increase in youth presenting to paediatric gender clinics over the past decade, as well as the shift in the demographics of presenting youth from being predominantly transfeminine individuals assigned male at birth to transmasculine individuals assigned female at birth (Marchiano, 2017; Littman, 2018). While the general consensus of medical and mental health providers is that this increase corresponds with a cultural shift towards greater acceptance of trans and gender-diverse youth, individuals who feel left behind by the paradigm shift in favour of gender-affirming care have instead latched on to the notion of ROGD (Kennedy, 2022). The broad awareness and popularity of ROGD was facilitated by a lay publication of the same theory by Abigail Shrier, who has since propagated this idea at ultra-conservative outlets, such as the Values Voter Summit (Shrier, 2020; Tannehill, 2021). Shrier’s ability to quickly market ideas from secular researchers to an evangelical conservative base was made possible, in part, by her publisher, Regnery, which is better known for the anti-abortion and social-conservative literature that makes up the majority of its catalogue.

Proponents of ROGD suggest that the rise in transgender youth, and specifically transmasculine youth, is the result of a form of ‘psychic contagion’ (Marchiano, 2017). Marchiano suggests that younger generations have become preoccupied with identity politics, with trans identities offering social credibility for youth who feel otherwise socially outcast. Paying homage to the regressive models of the previous century which hypothesised that transgender identities were often the product of a developmental inability to process one’s sexual orientation (Moser, 2010), it was proposed that masculinising transition was a rejection of lesbian attraction (Marchiano, 2017; Littman, 2018; 2019; Ashley, 2020b). Proponents of this theory received support from colleagues at the Tavistock and Portman NHS Foundation Trust, who claimed that children were being taken to the Tavistock Gender Identity Services (GIDS) for medical transition by parents whose dismay at learning they had a gay child led to the search for a medical solution (Short, 2019; Ashley, 2020a).

As has been pointed out by numerous transgender scholars, there are several fundamental problems with the ROGD hypothesis, as well as the data from which it was derived (Short, 2019; Ashley, 2020a; Restar, 2020; Kennedy, 2022). Both Littman and Marchiano relied heavily on the reports of parents whose stories were sought out specifically because they believed their children had experienced the phenomenon being thus reported (Ashley, 2020a; Restar, 2020; Bauer et al, 2021). Littman’s sample
was recruited from message boards favoured by estranged parents seeking solace from others in similar situations (Ashley, 2020a), while Marchiano’s was based on unstructured communication with friends and the parents of clients. Neither sample included the voices of parents who took no issue with their children’s transgender identities, nor did they actively seek out stories disconfirmatory of their primary hypothesis. Furthermore, the notion that being transgender is a socially attractive identity fails to account for the astronomically high rates of bullying, violence and ostracisation towards trans and gender-diverse youth consistently found in social-epidemiological studies with school-aged children (Casey et al, 2019; Johns et al, 2021; Messinger et al, 2021).

Proponents of the idea that medicalised transition is an attempt to ‘convert’ sexual-minority children to heterosexual ones also fail to account for existing sexual orientation data on gender-diverse youth which reveal that the majority of transgender youth identify as sexual minorities (for example, lesbian, gay, queer, bisexual or pansexual). In a purposive sample of US youth ($N = 3,318$), only 64 (3 per cent) of transgender youth in the sample identified as heterosexual, compared to 647 (47 per cent) of cisgender youth (Salk et al, 2020). Transgender respondents most frequently identified as bisexual or pansexual (totalling 927 [48 per cent] of transgender participants.) Taken as a whole, evidence suggests that the ROGD hypothesis unnecessarily problematises the more rational explanation, namely, that what gender-diverse youth experience when they see themselves reflected in someone whose experience is similar to their own is self-recognition, not contagion or psychopathology (Kennedy, 2022).

The outcry from experts within the transgender community prompted a swift response from PLoS One, the journal who originally published Littman’s (2019) study (Heber, 2019). Not only was the title changed to reflect the lack of youth self-report or perspective in the data-collection process (Heber, 2019), but a lengthy correction was also printed acknowledging the flaws in the study, as well as a statement from Littman’s then-employer (Brown University, 2019). An additional correction and apology to the transgender community was published on the journal’s blog, with the acknowledgement that these concerns should have been addressed prior to publication (Heber, 2019). Subsequent research challenging the ROGD hypothesis has found that attempts to quantitatively study the purported phenomenon have not supported the original hypothesis (Bauer et al, 2021).

Despite the mounting evidence against the ROGD hypothesis, there has been a lack of guidance from either prominent schools of social work or our professional associations to address licensed providers who are endorsing and publicising ROGD as a diagnostic paradigm. The lack of confirmatory evidence has also not stopped lawmakers, who continue to propose legislation to criminalise gender-affirming healthcare. Utah State Representative Rex Shipp, whose Bill HB 92 would propose an almost identical ban as Texas’s SB 23, cited ‘Rapid Onset Gender Dysphoria’ in the text of the bill itself. In a supplemental, which counts licensed social workers Phillip Sutton and Shirley Cox as contributors, the bill sponsors claim that the rise in cross-gender identification is due to pornography and autism spectrum disorder (Shipp, 2021; Shipp and Bramble, 2021).
A new paradigm of gender and social work

Many calls exist across disciplines for true collaboration and the inclusion of transgender/non-binary people in the design, implementation and evaluation of services of all kinds. Social work must not only include trans voices, but also take steps to increase support for transgender voices in our schools of social work and training programmes (Timbers, 2020). We also need to attend to the fact that gender-diverse people are not a monolith. Some of the most strident attacks on transgender youth and their access to life-saving healthcare are coming from a group of women long established in gender care, including transgender women, such as surgeon Marci Bowers and the psychologists Laura Edwards-Leeper and Erica Anderson, the latter of whom is the former president of the United States Professional Association for Transgender Health (Edwards-Leeper and Anderson, 2021; Shrier, 2021). These attacks appear to stem from a lack of recognition that gender-identity processes differ across individuals, an unwillingness to accept the legitimacy of non-binary identities and a desire to codify a linear, binary transition pathway that may be less relevant to transmasculine youth. Interestingly, this line of reasoning brings them into alignment with a particular group of ‘gender-critical feminists’ who are concerned about the effects of gender diversity on conventional notions of womanhood and feel a need to protect their definition of femininity from threat (Tannehill, 2021).

The experience of transgender and gender-diverse individuals is just that: diverse. Social work principles recognising that individuals are experts in their own lives and requiring social workers to work against discrimination support a need for the field to accept and champion gender diversity. The field must also work to find ways to support individuals’ autonomy in self-identification, as well as their ability to live safely and functionally in broader society. This requires providing accepting spaces for individuals to explore and affirm their genders in the ways they choose, without imposing predefined narratives of cisnormativity or linear, binary transition as the only acceptable routes – an approach that is supported by both the evidence and a multiplicity of guidelines and standards of care from professional organisations (Rafferty and Radosh, 1997; World Professional Association for Transgender Health, 2011; American Psychological Association, 2015; Hembree et al, 2017; American College of Obstetricians and Gynecologists, 2021).

Social work organisations need to follow suit, with evidence-based practice guidance supporting gender-affirming standards of care. Cisgender professionals must be willing to not only prioritise trans voices and experiences, but also challenge those who would send transgender health back to its conservative, pathologising origins in order to protect their hegemonic influence over the field of gender care. In addition, as a field, we need to interrogate our theoretical bases and be open to an evidence base that is partial to those it impacts most heavily, ensuring that the intellectual short cuts that we take to explain social phenomena do not simply recast oppressive ideas as innovation. It is similarly essential that those working in solidarity with families of transgender and non-binary youth seek out newer family-systems research that moves beyond the grief model and towards a vision of a psychology, counselling and social work that stands in ardent solidarity with both transgender youth and their families. Trans- and queer-led research will help assure that trans voices are integral to shaping the future paradigms upon which social care and human service workers will rely (Katz-Wise et al, 2017; Bhattacharya et al, 2021). These new models offer
hope that we can break free of the idea that youth coming out as transgender is an inherently negative experience for families in favour of the liberating truth that for many families, it can be both joyous and profound (Katz-Wise et al., 2017; Pletta et al., 2021).

Transgender professionals must be willing to recognise that each of us experiences gender very differently and that our needs and histories are not proxies for others’ goals and lived experiences. For this reason, we must be diligent in our attention to intersectionality. What will be a simple additional step towards accessing gender affirmation for one person can be a lifetime barrier for another, reflecting social and economic inequities that span race, culture, class and other domains.

Social work as a profession must recognise that the world we are in changes rapidly and our intersubjective limitations prevent us from truly being able to understand the experiences of others – such as our transgender and gender-diverse colleagues, clients, friends, neighbours and other populations around the country and the globe. We must further recognise that such a lack of understanding is not evidence that those who hold perspectives outside of our grasp are any less legitimate or worthy of fundamental human-rights protections. It is incumbent upon the field to follow the evidence. While theorists may argue about the origin of transgender identity in perpetuity, the evidence is clear on the correct path forward. Transgender youth who are supported and affirmed have better mental health outcomes, report fewer behavioural risk factors and report higher satisfaction and quality of life when they are supported by their families (Simons et al., 2013; Bhattacharya et al., 2021). Transgender adults similarly benefit from access to gender-affirming care that supports their individual goals, accepting workplaces and other societal changes that reduce stigma and discrimination.

This generation, and that which will come after it, will hopefully be more liberated from gendered oppression. We have a fundamental professional and ethical imperative to protect this progress at all costs. Social work must support and elevate the voices of the most marginalised, not those who would keep them in that position to cement their existing privilege and power.

Notes
1 On one positive note, the US Supreme Court recently ruled in Bostock v. Clayton County (2020) that Title IX of the federal Civil Rights Act includes gender identity, reasoned on the grounds that assumptions about an individual’s sex are necessary for discrimination by sexuality or gender to occur, therefore placing such discrimination under the Civil Rights Act by legal precedent. However, the Civil Rights Act itself has no formal language protecting transgender people, and efforts to pass the national Equality Act have been successfully opposed by anti-transgender groups.

2 ‘Deadnaming’ is a term used by many transgender/non-binary people to describe being referred to by one’s given name, typically assigned at birth. For people whose given names carry a gendered connotation, deadnaming can be a form of misgendering, that is, the act of using one’s sex assigned at birth instead of their gender as a referent.

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**Conflict of interest**

The authors declare that there is no conflict of interest.

**References**


The role of social work and social welfare in the current crisis facing trans youth in the US


