

Suicide or transition: The only options for gender dysphoric kids?

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*This is the first in a series of articles authored by Drs. Bailey and Blanchard. As their time permits, they will be available to interact in the comments section of this post. **Please note:** As always on 4thWaveNow, if you disagree with the content of this article, your comments will be more likely to be published if they are delivered respectfully. Hateful or trollish comments will be deleted.*

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Ray Blanchard received his A.B. in psychology from the University of Pennsylvania in 1967 and his Ph.D. from the University of Illinois in 1973. He was the psychologist in the Adult Gender Identity Clinic of Toronto's Centre for Addiction and Mental Health (CAMH) from 1980–1995 and the Head of CAMH's Clinical Sexology Services from 1995–2010.

It is increasingly common for gender dysphoric adolescents and mental health professionals to claim that transition is necessary to prevent suicide. The tragic case of [Leelah Alcorn](#) is often cited as the rallying cry: “transition or else!” Leelah (originally Joshua) was a gender dysphoric natal male who committed suicide at age 17, blaming her parents for failing to support her gender transition and forcing her into Christian reparative therapy. Subsequently, various “Leelah’s Laws” banning “conversion therapy” for gender dysphoria (among other things) have been passed or are being considered across the United States.

The suicide of one’s child is every parent’s nightmare. Given the choice for our child between gender transition and suicide, we would certainly choose transition. But the best scientific evidence suggests that gender transition is not necessary to prevent suicide.

We provide a more detailed essay below, but here’s the bottom line:

1. Children (most commonly, adolescents) who threaten to commit suicide rarely do so, although they are more likely to kill themselves than children who do not threaten suicide.
2. Mental health problems, including suicide, are associated with some forms of gender dysphoria. But suicide is rare even among gender dysphoric persons.
3. There is no persuasive evidence that gender transition reduces gender dysphoric children's likelihood of killing themselves.
4. The idea that mental health problems—including suicidality—are caused by gender dysphoria rather than the other way around (i.e., mental health and personality issues cause a vulnerability to experience gender dysphoria) is currently popular and politically correct. It is, however, unproven and as likely to be false as true.

Suicide vs Suicidality vs Non-suicidal Self-injury

Suicide is a rare event. In the United States in 2014, about 13 out of every 100,000 persons committed suicide. Suicide was most common among middle aged white males, who accounted for about 7 out of 10 known suicides.

It is helpful to distinguish at least four different things: *Completed suicide* means death by suicide. *Suicidality* means either thinking about committing suicide or attempting suicide. *Non-suicidal self-injury* means injuring oneself (most often by cutting one's skin) without intending to die. Finally, *mental illness* includes a variety of conditions, from depression to conduct disorder to personality disorders (such as borderline personality disorder) to schizophrenia—some of which are especially strongly associated with completed suicide and suicidality, others of which are more strongly associated with non-suicidal self-injury.

Obviously, completed suicide is what we are most worried about. Because it is so rare, however, and because it is often difficult to know about the dead person's motivations for suicide, it has been especially difficult to study. There are fewer studies focusing on gender dysphoria and completed suicide than on gender dysphoria and either suicidality or non-suicidal self-injury. Studies of suicidality must rely on self-report (for example, someone must report that they are, or have been, thinking about committing suicide), and this complicates interpretations of results. (Maybe some people, some times, are especially likely to say they have been suicidal, even if they haven't been.) Also there is more than one kind of gender dysphoria—we think there are three (this is a topic for another day)—and we should not expect risks to be identical for all types.

The Scientific Literature

Our aim here is not to review every available study, but to focus on the best evidence. Larger, more representative studies—and most importantly, studies of completed suicide—are most informative.

Studies of Completed Suicides

Two large systematic studies of completed suicide and gender dysphoria have been published, one from the Netherlands, the other from Sweden. Notably, both countries are socially liberal, and both studies were conducted fairly recently (1997 and 2011). Both studies focused on patients who had been treated medically at national gender clinics. These patients all either

began or completed medical gender transition, and we refer to them as “transsexuals.” (We don’t know how many of the patients there were from each of the three types we believe exist.)

The [Dutch study](#)’s suicide data were of male-to-female transsexuals (natal males transitioned to females) treated with cross-sex hormones (and many also with surgery). Of 816 male-to-female transsexuals, 13 (1.6%) completed suicide. This was 9 times higher than expected. Still, suicide was rare in the sample. The [Swedish study](#) found an even larger increase in the rate of suicide, 19 times higher among the transsexuals than among a non-transsexual control group. Still, only 10 out of 324 transsexuals (i.e., 3.1% of the group) committed suicide. Again, still rare. Note that both studies were of gender dysphoric persons who transitioned. As such, their results hardly support the curative effects of transition.

The Dutch and Swedish studies were of adults whose gender dysphoria may or may not have begun in childhood. No published study has focused only on childhood onset cases. However, psychologist Kenneth Zucker has tracked the outcome of more than 150 childhood onset cases treated at the Centre for Addiction and Mental Health into adolescence and young adulthood. He has generously shared with us (in a personal communication) his outcome data for suicide. Out of those more than 150 cases followed, only one had committed suicide. Furthermore, Dr. Zucker’s understanding (based on parent report) is that this suicide was not due to gender dysphoria, but rather to an unrelated psychiatric illness. On the one hand, one suicide out of 150 cases is more than we’d expect by chance. On the other hand, it is a rare outcome among gender dysphoric children and adults.

Studies of Suicidality and Non-suicidal Self-injury

People who commit suicide were suicidal before they did so. But most people who are suicidal do not commit suicide. “Suicidal” is necessarily a vague word, encompassing “intends to commit suicide” and “thinks about suicide,” both in a wide range of intensity. Furthermore, most studies would include as “suicidal” someone who falsely reports a past or present intention to commit suicide.

Why would anyone falsely report being suicidal? One reason is to influence the behavior of others. Saying that one is suicidal usually gets attention–sympathy, for example. It can be a way of impressing others with the seriousness of one’s feelings or needs. Although this possibility has not been directly studied, reporting suicidality may sometimes be a strategy for advancing a social cause.

[According to data from the Centers for Disease Control](#) (CDC), the rates of intentional but non-fatal self-injury peak during adolescence at about 450 per 100,000 girls and a bit fewer than 250 per 100,000 boys. These rates are much higher than the 13 per 100,000 American completed suicides per year (and remember that suicide is more common among adults than adolescents). So it is reasonable to assume that most adolescent self-injury is not intended to end one’s life. We are not suggesting that parents ignore children’s self-injury. We simply mean that self-injury often has motives besides genuinely suicidal intent.

Not surprisingly, given the increased rates of suicide among gender dysphoric adults, suicidality (i.e., self-reported suicidal thoughts and past “suicide attempts”) is also higher among the transgendered. One [recent survey](#) statistically analyzed by the Williams Institute reported that 41% of transgender adults had ever made a suicide attempt, compared with a rate of 4.6% for controls. This survey recruited respondents using convenience sampling, however, and this may

have inflated the rate of suicidal reports. Additionally, the authors of the survey included the following (admirable) disclaimer):

Data from the U.S. population at large, however, show clear demographic differences between suicide attempters and those who die by suicide. While almost 80 percent of all suicide deaths occur among males, about 75 percent of suicide attempts are made by females. Adolescents, who overall have a relatively low suicide rate of about 7 per 100,000 people, account for a substantial proportion of suicide attempts, making perhaps 100 or more attempts for every suicide death. By contrast, the elderly have a much higher suicide rate of about 15 per 100,000, but make only four attempts for every completed suicide. Although making a suicide attempt generally increases the risk of subsequent suicidal behavior, six separate studies that have followed suicide attempters for periods of five to 37 years found death by suicide to occur in 7 to 13 percent of the samples (Tidemalm et al., 2008). We do not know whether these general population patterns hold true for transgender people but in the absence of supporting data, we should be especially careful not to extrapolate findings about suicide attempts among transgender adults to imply conclusions about completed suicide in this population.

That is, importantly, the authors realize that suicidality and completed suicide are very different things, and it is suicidality that they have studied. Completed suicides in their group will be much, much lower.

Increased suicidality for gender dysphoric children was also reported by parents in a recent [study](#) by Kenneth Zucker's research group.

A systematic [review](#) of non-suicidal self-injurious behavior in "trans people" found a higher rate, especially for trans men (i.e., natal females who have transitioned to males). The most common method mentioned was self-cutting. (Self-cutting is a common symptom of borderline personality disorder, which is also far more common among non-transgender natal females than among natal males.)

Is Transition the Answer, After All?

In a very recent study psychologist [Kristina Olson reported](#) that parents who supported their gender dysphoric children's social transition rated them just as mentally healthy as their non-gender-dysphoric siblings. Furthermore, parents' reports suggested that the socially transitioned gender dysphoric children were not less mentally healthy than a random sample would be expected to be.

This research falls far short of negating or explaining the findings we have reviewed above. First, it was relatively small, including only 73 gender dysphoric children. Second, families were recruited via convenience sampling, increasing the likelihood of various selection biases. For example, it is possible that especially mentally healthy families volunteer for this kind of research. Third, the assessment was a brief snapshot; we would expect socially transitioned gender dysphoric children to be faring better at that snapshot compared with children struggling with their gender dysphoria. (There is little doubt that at first, gender dysphoric children are happier if allowed to socially transition.) Young gender dysphoric children do not show that many psychological or behavior problems, aside from their gender issues. The aforementioned [study](#) by Kenneth Zucker's research group showed that mental health problems, including suicidality, increased with age. Perhaps this won't happen with Olson's participants, but it's too soon to know.

Why Is Gender Dysphoria Associated with Mental Problems, Including Suicidality?

We don't know.

The current conventional wisdom is that gender dysphoria creates a need for gender transition that, if frustrated, causes all the problems. That is a convenient position for pro-transition clinicians and activists. But they simply don't know that this is true. Furthermore, both our past experience studying mental illness scientifically and specific findings related to gender dysphoria suggests the conventional wisdom is unlikely to be correct.

As an example, Leelah Alcorn's suicide (like most suicides) was tragic, but she appears to have had problems that were not obviously caused by her gender dysphoria. She posted as Joshua (her male identity) on Tumblr:

"I'm literally such a bitch. shit happens in my life that isn't even really that bad and all I do is complain about it to everyone around me and threaten to commit suicide and make them feel sorry for me, then they view me as sub-human and someone they have to take care of like a child. then when they don't meet my each and every single expectation I lash out at them and make them feel like shit and like they weren't good enough to take care of me. since I can only find imperfections in myself I try my hardest to find imperfections in everyone around me and use them as a way to one up myself and make others feel bad to make myself look better."

Sophisticated causal analysis of mental illness and life experiences has invariably shown that things are more complex than previously assumed. For example, although depression is certainly caused by adverse life experiences, [those vulnerable to depression have a tendency to generate their own stressful life experiences](#). So it's not as simple as depression being caused by life experiences alone. Also, depression has a considerable genetic influence. Similarly, women with borderline personality disorder (BPD) report that they have experienced disproportionate childhood sexual abuse (CSA), and [many clinicians and researchers have assumed that CSA causes BPD](#). But one just can't assume the causal direction goes that way—one must eliminate [alternative possibilities](#). Recent sophisticated studies suggest that, in fact, [CSA does not cause BPD](#).

Research to understand the link between gender dysphoria, various mental problems (including suicidality), and completed suicides will take time. There is already plenty of reason, however, to doubt the conventional wisdom that all the trouble is caused by delaying gender transition of gender dysphoric persons. We have already mentioned the fact that transitioned adults who had been gender dysphoric (i.e., "transsexuals") have increased rates of completed suicide. Their transition did not prevent this, evidently. Suicide (and threats to commit suicide) can be [socially contagious](#). Thus, social contagion may play an important role in both suicidality and [gender dysphoria itself](#). Autism is a risk factor for both [gender dysphoria](#) and [suicidality](#). No one, to our knowledge, believes that gender dysphoria causes autism.

Conclusions

Parents with gender dysphoric children almost always want the best for them, but many of these parents do not immediately conclude that instant gender transition is the best solution. It serves these parents poorly to exaggerate the likelihood of their children's suicide, or to assert that suicide or suicidality would be the parents' fault.

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