SEXUALITY POLICY WATCH

Gender affirmation and evidence around suicide: Contributions to public debate[1]

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The Cass report, published in April this year, is an extensive review of evidence around gender-affirming care for trans and gender non-conforming children and adolescents. Commissioned by the National Health Service (NHS) in England, it sought to understand why the demographic profile of those consulting gender identity services has changed and to identify the best clinical approach to meet their needs. Alongside this, Dr Hillary Cass and her team reviewed the state of the evidence about the use of medical and non-medical interventions for trans and gender non-conforming children and adolescents, concluding that the level of certainty about their effects and benefits is 'low'.

The publication of the report has had a global impact. For example, the Ministry of Health in Chile issued in June the so-called Circular No. 7. In a hasty move, it instructed the national public health service network to *defer* new admissions of adolescents who want to start their treatment with puberty blockers and cross-hormone therapy. Concurrently, it convened representatives of the country's scientific societies with experience in working with transgender people and their families to set up a Panel of Experts to contribute to the development of 'technical guidelines' to orient the provision of gender-affirming hormone therapy for adolescents. Lastly, the Chamber of Deputies also approved the creation of an Investigative Commission to inquire into the functioning of the country's trans health programmes. The commission, which extended its mandate until November 4, is expected to hear experts from civil society and academia, as well as testimonies from service users and their families.

While the focus of the discussion has centred around the medical aspects of gender-affirming care, another dimension of the debate has involved the mental health issues of trans people, including suicide, and their relationship to access to affirmative health care.

[1] This piece was originally published in Spanish on 23 September 2024 on the *Sexuality Policy Watch* website. This translated version was edited and expanded to help readers outside of the Chilean and Spanish-speaking region to understand some context-specific references.

In the wake of the Cass report, some media outlets, columnists and activists have shared information claiming that the review allegedly did not find *conclusive evidence to account for the positive impact of gender-affirming care on the well-being of trans and non-binary people*. Among the sloppy and careless claims that have circulated, it has been suggested that the evidence around suicide, as a trans-specific public health issue, has been used as a 'threat' and a coercive strategy by 'trans activism' to 'force' or 'push' parents and/or family networks to support their children's transition. Rather than contributing to a serious and careful debate on suicide, these publications cast doubt on the available evidence on the subject and the existing relationship between suicidality and various social stressors, such as lack of family support, barriers to accessing health care, discrimination and gender disaffirmation, among others.

The use and interpretation of suicide epidemiology should be evaluated based on its merits and following a *case-by-case ethics*. However, we are concerned that in the current discussion around gender-affirming care, the existing evidence about suicide is at risk of being disregarded. As a result, we argue, the negative impact of interventions and legislative initiatives seeking to ban, limit, or deny LGBTQIA+ people's right to health is being underestimated, particularly for adolescents.

To contribute to a responsible and evidence-based discussion, we discuss three issues in this piece: 1) first, we review some of the existing evidence around the complex phenomenon of suicide, paying attention to the uniqueness of the experience of trans lives, a particularly vulnerable social group in Chile; 2) second, we situate this discussion vis-à-vis the Cass report, contextualising its main findings and criticisms; 3) and lastly, we analyse the relationship between gender-affirmative interventions, particularly medical ones, and suicide mortality, critically discussing some of the political uses that have been made of the evidence reviewed in the Cass report by anti-trans actors, which seek to ban or restrict access to gender-affirming care. The latter, in our view, violates the right to health of trans, non-binary and gender-diverse people, particularly adolescents.

Photo credit: Tomás Ojeda
The poster on the right reads: "Trans kids exist and resist!"

SUICIDE AND THE TRANS COMMUNITY

Suicide is a complex and multidimensional phenomenon shaped by socioeconomic, cultural, social and geographical factors (Institute of Medicine, 2022; PAHO, 2022). In addition to the occurrence of mental health disorders, other risk factors associated with suicide include experiences of loss, feelings of loneliness, discrimination, breakdown of love relationships, financial problems, chronic illness and pain, violence, abuse and health emergencies (WHO, 2023). Studies also note that a leading risk factor is having had a previous suicide attempt (PAHO, 2021). A study carried out in Chile found that the risk of severe depressive symptoms is almost three times higher in people with low social support (Jiménez-Molina et al., 2021). In contrast, having such support is an important predictor of resilience (Simon et al., 2021).

Both the World Health Organisation (WHO) (2023) and the United Nations (UN) (2016) recognise that there are specific groups that are more vulnerable to suicide risk. For

example, women and children, youth, older people, migrants, lesbian, gay, bisexual, trans, intersex, non-binary, gender non-conforming and other sexual and gender diverse and dissident[2] groups. Increased vulnerability is not explained solely by belonging to one of these groups; nor is it explained by a cause-effect relationship between two or three factors. Instead, it is driven by the interaction of complex social dynamics that enhance the previously mentioned risk elements.

Research shows that inequalities and disparities in the mental health of LGBTIQA+ people are explained by a combination of factors that, if not addressed in a comprehensive manner, contribute to emotional distress and chronic stress. What are those factors?

On the one hand, there are factors described by the 'minority stress model', which helps us to understand the social determinants that negatively affect mental health indicators of people from various minoritised groups. These include victimisation, LGBTIQA+ hateful violence, discrimination, gender invalidation and disaffirmation, among others (Martínez et. al., 2018; Meyer, 2003; Testa et. al., 2015). On the other hand, we have factors produced by the lack of training of health professionals about the specific needs of LGBTIQA+ people, the lack of political will to improve the way services are provided, the lack of monitoring and evaluations of public services, and socio-cultural constructions about sexual and gender diversity and dissidence that promote stigma, pathologisation and barriers to access to medical care (Martínez, Tomicic and del Pino, 2019; Tomicic et. al., 2016).

In a systematic review led by Lauren Bochicchio on the determinants that influence suicidality[3] among trans adolescents, the analyses show a consistent relationship between suicidal behaviours, depressive symptoms, gender-based victimisation, bullying and lack of support from parents and caregivers. Furthermore, international evidence indicates that the prevalence of suicide attempts among trans people is 23% - 50% higher than in their cisgender peers (Klein and Golub, 2016; Moody and Grant, 2013; Peterson et al., 2017; Tucker, 2019). This is related to the systematic experience of

[2] The concept 'sexual dissidence' has a long and rich history in Chile and the South Cone's post-dictatorship *cuir*/queer scene. It is usually used as an alternative to the more 'sanitised' concept of 'diversity', and as a practice that disrupts the way cis-heteronormativity constructs 'difference' as minoritised and bounded to a fixed, legible and classifiable identity.

[3] Suicidality comprises a broad spectrum of manifestations, including suicidal thoughts, making a plan and obtaining the means to carry it out, as well as experiencing suicide attempts and losing one's life as a result.

violence, discrimination and non-recognition. These experiences affect trans people's mental health differently at structural (e.g., social stigma), interpersonal (e.g., family stigma) and individual (e.g., internalised stigma) levels (Reisner et al., 2016; Scandurra et al., 2018; Hughto-White et al., 2015).

Moreover, the evidence is clear that family and peer support, alongside a sense of belonging to a social group, are associated with less psychological distress and suicidal ideation among trans people (Tan et al., 2020). A systematic review on self-harming thoughts and behaviours led by Katherine Bird in 2024, reviewed 78 studies published between 2007 and 2023 in 16 countries with a total sample of 322,144 participants. This study found that the main protective factors in trans and gender-diverse populations are social support, safe school environments, use of their social names, experiences of non-discrimination in the health system and the existence of protective government policies.

At the national level, statistical evidence gathered during the COVID-19 pandemic confirms the special condition of vulnerability of the trans and LGBTIQ+ population in general. Regarding the latter, the report on LGBTIQ+ mental health developed jointly by Chilean researchers from the Movement for Sexual Diversity (MUMS), the Alberto Hurtado University (UAH) and the Catholic University of the North (UCN), showed that 5 out of 10 men thought of dying by suicide and 2 of them reported attempted suicide; 7 out of 10 women thought of dying by suicide and 3 of them experienced suicide attempt; while 7 out of 10 trans and non-binary people thought about suicide, with 4 of them having experienced suicide attempt (Ulloa, 2020). In another study, the National Network of Offices for Diversity, Inclusion and Non-Discrimination showed that high levels of psycho-emotional distress in the LGBTIQ+ population were associated with the interruption of medical treatments, such as hormone treatments for trans people, and the forced return to homes where discrimination and non-recognition were common (Red Diversa, 2020). The last study of note is the National Survey on Health, Sexuality and Gender (ENSSEX) 2022-2023, with a sample of 20,932 people out of an estimated 13,584,610 people living in the country, have been released. From the report developed by Todo Mejora Foundation, with the collaboration of some civil society organisations, we know from the survey that there is a significant difference in the prevalence of suicidal ideation and/or planning among LGBTIQ+ people versus cisgender heterosexual people, ranging from 39.7% to 16%, respectively (Todo Mejora, 2024). The latter not only confirms the presence of the phenomenon of suicide in the country, but also the need to facilitate access to the health care system and to promote protective factors for its prevention.

THE CASS REPORT

Returning to the introduction, it is important to distinguish between two terms that are often used interchangeably in current debates around gender-affirming care: the 'Cass review' and the 'Cass report'. The 'Cass review', named after the project's lead researcher, paediatrician Hillary Cass, is an extensive investigation into the state of health care received by trans and gender non-conforming children and adolescents in the English health system.[4] The review, which spanned four years, published its main findings in a 388-page report that was made available at the end of April this year and has had a transnational impact (Cass, 2024).

What is the scope of the report and what are its main recommendations? The report is a document of interest to all those working in the field of health and human rights. It should be read keeping in mind how it originated and the local 'diagnostics' to which it seeks to respond. The report, however, is not a clinical guideline or a working manual. Unlike the systematic reviews from which it draws its conclusions, the report is not a scientific publication and was not submitted to a peer-reviewed journal. Furthermore, it does not produce new evidence or find any evidence of harm caused by social transition and the use of medical treatments such as puberty blockers and cross-sex hormones.

The Cass review concludes that the level of certainty we have about the effects and benefits of using masculinising/feminising hormones and puberty blockers is 'low'. This does not mean that the evidence is bad or that the interventions are harmful. That the evidence is of 'low quality' means that it is not possible to establish causal relationships between benefits and interventions. In this regard, it is worth mentioning that there are interventions in paediatric medicine that continue to be implemented with 'low' levels of certainty, as is the evidence for the use of puberty blockers for cisgender children with precocious puberty. Despite the 'low' evidence, we do not stop practising them.

The report calls for a holistic and individualised assessment of children and adolescents, to design a support plan that involves families, specialist teams and children and young people. In this regard, and despite existing prejudices about gender-affirming care, Cass and her team's audit of gender identity services in England found no evidence to

[4] For those who want to delve deeper into the report, we recommend reading this preliminary analysis by researchers Tomás Ojeda and Rodrigo Sierra (in Spanish). In it, they discuss the UK context and elements that explain the origins of the Cass review and some of the report's weaknesses that are relevant to consider when interpreting its recommendations.

support the belief that patients receive medical treatment in a rushed and hurried manner. In fact, most people wait on average 2-3 years to be seen by a specialist (Appendix 8, Cass Report). Once they move up on the waiting list, they attend an average of 6.7 assessment sessions, and once they are referred to endocrinology, they wait several more months to start their treatment. This is an important finding of the report that has been little publicised and buried in the news: the media attention tends to be on the alleged 'rushed' treatment and not on the waiting lists or the number of sessions required to assess patients' suitability for treatment.

Finally, the Cass report also suggests that better evidence on the effects of medical interventions in the field of trans health should be developed to ensure a safe and effective care system. Before this occurs, Cass recommends that puberty blockers be given to children and adolescents only in the context of a clinical trial, which, to date, has not been carried out.

Photo credit: Franco Fuica
The banner reads: "Trans childhoods supported, celebrated and non-pathologised!".

Although the final report was welcomed by the mainstream press and organisations opposed to trans rights, critical analyses of the Cass report have gradually appeared from professionals with extensive and recognised experience in the field of trans health, social sciences and epidemiology. They have compellingly exposed some of the report's methodological flaws and the undue interpretation of the report by those who have used the document to advance their own anti-rights agendas.

Paediatrician Max Davie and clinical psychologist Lorna Hobbs (2024) summarised the main criticisms as follows:[5] 1) the Cass review minimises the benefits of medical interventions; 2) ignores the potential harms of not offering treatment; 3) makes inappropriate use of systematic reviews referring to non-medical interventions;[6] 4) exaggerates alleged harms of social and medical transition; 5) incorrectly asserts that most trans adolescents 'outgrow' or 'resolve' their gender dysphoria in adolescence; 6) fails to consider the expertise of those who work in trans health and those who are experts by experience; and 7) delegitimises trans identities and only refers to trans childhood in medical and diagnostic terms (e.g., *children with gender dysphoria*)[7].

THE RELATIVISATION OF SUICIDE EVIDENCE

In light of the Cass review, various individuals and groups who oppose gender-affirming care have shared their prejudiced opinions in the press and on social media. These have contributed to relativising the existing evidence about suicide risk among trans and non-binary individuals. Many of these opinions derive from an uninformed and irresponsible reading of the systematic reviews that fed into the final

[5] Davie and Hobbs based their critical assessment on the analysis of the scientist and epidemiologist Gideon Mayerowitz-Katz (2024b).

[6] The report prioritises psychological accompaniment as an alternative without offering evidence for it. As the reviews conducted by researchers at Yale University (McNamara et al., 2024), and the analyses by Davie and Hobbs (2024), and Mayerowitz-Katz (2024b) point out, the team conducting the systematic reviews for the Cass report (University of York) used a completely different set of criteria to assess the quality of evidence for psychosocial interventions than criteria they used to evaluate the evidence for cross-sex hormone therapies and puberty blockers. Furthermore, they did not exclude low-quality studies, as in the other reviews, which is considered a significant deviation from the protocol. The Cass review team did not explain the rationale behind this methodological decision. This methodological choice has been conveniently omitted in the coverage by most media, some columnists and anti-trans health groups.

[7] Sociologist and trans health researcher Ruth Pierce delves into this and other criticisms of the Cass report in this episode of the Red Medicine podcast.

recommendations of the Cass report. Columnists, activists, media and journalists in the UK, US and Chile, among other countries, have claimed, for example, that Cass did not find conclusive evidence to show the positive impact of gender-affirming practices—such as the use of puberty blockers or cross-sex hormones—on people's psychosocial wellbeing.

However, we know that the fact that evidence is inconclusive, does not mean that there is no improvement or positive outcomes associated with the effect of certain health interventions. Or, as the Yale University team (McNamara et al., 2024) states, the fact that some studies show no change in some mental health outcomes indicates *stability* rather than no effect. And stability is a relevant indicator in the short term, especially for trans adolescents who may experience significant distress in the absence of treatment.

The best evidence to date suggests that the use of puberty blockers does have a positive impact on people's mental health outcomes. The problem is the type of questions we ask the evidence to assess its impact—in other words, what we expect the evidence to say when assessing its effectiveness and overall impact. For example, as those working in the field of trans health are well aware, puberty blockers *alone* do not decrease gender dysphoria rates (McNamara et al., 2024). As Cal Horton (2024) notes, blockers "don't magically make trans kids feel better about their primary sexual characteristics.[8] Instead, they prevent the increase in gender dysphoria that can occur at puberty, if adolescents denied blockers are forced through the distressing development of unwanted secondary sexual characteristics". Simply put, these medications are effective in halting the development of puberty-induced characteristics that may negatively affect the psychosocial well-being of trans adolescents. They alone do not *cure* or *reduce* dysphoria.

Several recent critical appraisals of the Cass report agree that the evidence that was reviewed in relation to gender-affirmative health did show improvements in indicators of suicidality, depression and anxiety. However, these findings were omitted in the report's final recommendations (Grijseels, 2024; McNamara et al., 2024; Noone et al., 2024). For example, systematic reviews conducted by researchers at the University of York regarding the use of hormone replacement therapy and puberty suppression found a number of studies rated as 'high and moderate' quality by Cass standards that did show a positive association between hormone therapy and psychological

[8] Primary sex characteristics are the sex organs present at birth. Secondary sexual characteristics are those non-genital physical traits that appear at puberty (e.g. breast development, voice tone, growth of facial hair, etc.).

well-being. All of these studies documented improvements in gender dysphoria, body satisfaction, depression, anxiety, psychological functioning, suicidality and self-harm. None of them reported 'consistent' evidence of harm.

Another study that is often cited to dismiss the benefits of gender-affirmative health on suicide rates is a recent study conducted in Finland (Ruuska et al., 2024). As an example, one news report published in the *New York Post* positively welcomed the Finnish study, claiming that it "*found that providing cross-sex hormones and gender-transition surgeries to adolescents and young adults didn't appear to have any significant effect on suicide deaths*". This line of argument has been used politically to claim that "gender-distressed young people" do not need hormones or any gender-affirming medical intervention but counselling.

The Finnish study has been criticised by researchers in the field of medicine and epidemiology, such as Meredithe McNamara (2024) and Gideon Meyerowitz-Katz (2024a), whose responses to the study were even published in the same journal. The study uses data from a time before the diagnostic category of 'gender dysphoria' was introduced in the diagnostic-medical lexicon (which only appeared in the DSM-5 in 2013). This means that it included people in the sample who were not trans, but rather children whose behaviours were more gender non-traditional or non-conforming according to specific socio-cultural standards (*effeminate* or *masculine,* respectively). In addition to this, another important criticism states that the study findings themselves show a reduction of at least two-thirds in the risk of suicide, which is a far cry from how these results have been communicated and the political uses that have been made of them (Meyerowitz-Katz, 2024a).

What, then, would be the intention of citing this Finnish study or omitting criticisms of the Cass report from the media and press coverage? It seems that the aim is primarily to ban or further restrict access to gender-affirming care. This is particularly troubling because the data referenced by groups opposing this kind of affirmative care show no evidence of harm, especially when done under medical supervision and with family support.

It is important to reinforce that the Cass report does not provide any evidence of harm and, therefore, should not be used as evidence of alleged *evils* that do not appear in the recommendations. For example, the report has been used politically to justify banning and criminalising the use of puberty blockers for trans adolescents under the age of 18

in England, Scotland and Wales,[9] and in almost 10 US states. By promoting further restrictions on gender-affirming care, we risk contributing to the stress, uncertainty and distress of trans adolescents and their families, who have seen the continuity and availability of their treatment threatened.

Photo Credit: Nikolas Gannon, Unsplash.

INFORMATION, COMMUNICATION AND CITIZEN RESPONSIBILITY

To prevent suicide, it is crucial to be able to talk about it in a safe and frank way. The *Millennium Nucleus* Project *to Improve Adolescent and Youth Mental Health* (Imhay) strongly warns us to be careful about the words we use to refer to this topic. It is

[9] In our view, the ban on trans, non-binary and gender non-conforming people is clearly discriminatory and ideologically driven as it does not apply to cisgender children who use blockers to treat precocious puberty.

recommended to avoid promoting views that stigmatise suicidal behaviours and avoid detailed descriptions or comparisons of suicides (IMHAY, 2022). Adequate dissemination of information and awareness-raising are essential for its prevention. It is important to inform that suicide is a global problem and a public health and safety issue, avoiding communication styles that sensationalise or stereotype suicide. Using credible sources and accurate statistics is also crucial in this prevention endeavour (IMHAY, 2022).

By considering this need for careful communication about suicide, the responsible use of evidence is key; especially because we have a robust body of research that supports this communication approach and warns us about the risks to which some minoritised groups are exposed. In this sense, it is the job of the media, public policy, and health professionals to disseminate accurate information and make it accessible to prevent avoidable harm. These ethics and care underpinning suicide prevention are shared by all people working in the health sector, not only by those who work from a gender-affirmative approach.

In this context, we hope that the discussion around the evidence on gender-affirming care, mental health and wellbeing will be conducted responsibly, in dialogue with the community, and with attention to the recent work we have referenced in this essay. We hope so without forgetting that when it comes to suicide prevention, there is robust and socially committed research in Chile from which we can continue to learn.

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