Family Watch International

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Family Policy Brief

Understanding Transgender Issues: Suicide Risk

This policy brief is part of a series examining transgender issues posted in FWI's Family Policy Resource Center at familywatch.org.

Executive Summary

Transgender activists often assert that affirming the preferred "gender identity" of transgender persons and providing them with access to cross-sex hormones and surgeries is essential to preventing them from committing suicide. Activists claim suicidality and other mental health problems result from transphobia, stigma and discrimination, as well as a lack of support or affirmation by others of a person's self-perceived gender identity. Moreover, parents of gender-confused children are often pressured to collude with their child's self-declared "gender identity" fantasy and are accused of contributing to their child's suicidality if they do not.

However, if societal factors such as discrimination or lack of collusion and affirmation were the major contributors to transgender suicidality, we would expect suicide rates to be lower in communities where transgender identities are supported and affirmed and higher where they are not—but that is not what research shows.

There is no research showing that either cross-sex social affirmation or medical procedures have reduced suicides among those who identify as transgender. In fact, key studies have provided some evidence that social, medical and surgical affirmation of cross-sex identities might actually increase suicidality instead. Further, underlying mental health conditions that may contribute to the dysphoria of transgender people have largely been left untreated, and they often have been denied the help they really need as it has become politically incorrect to imply there could be any kind of link between mental illness and gender dysphoria.

Although all suicide threats should be taken seriously, such threats have sometimes been used by youth and health care providers, as a form of manipulation to coerce parents into allowing their children to receive life-altering transgender medical procedures. The threat of transgender individuals committing suicide is often used as a reason to enact policies that impose forced affirmation of transgender identities.

Data on Transgender Suicidality

The following studies suggest a strong association between transgender identification and suicidality in general:

- Over a dozen separate surveys of transgender adults from Canada, Ireland, Belgium, Germany, the United States and the United Kingdom found lifetime suicide attempts reported by 25-43 percent of transgender respondents—compared to 4.6 percent of the general U.S. population and 10-20 percent of lesbian, gay and bisexual adults.[1]

- The 2015 U.S. Transgender Survey (published by the National Center for Transgender Equality) reported that among the transgender population,
    - Forty percent (40%) have attempted suicide *in their lifetime*, almost nine times the rate in the U.S. population (4.6%);
    - Seven percent (7%) attempted suicide *in the past year*—almost twelve times the rate in the U.S. population (0.6%).[2]

- The National Transgender Discrimination Survey (NTDS) of 6,450 persons who self-identify as transgender published in 2011 found that 41 percent said they had attempted suicide, versus 1.6 percent of the general public.[3] Five years later, one of its authors acknowledged that "the statistic about suicide attempts has, in essence, developed a life of its own. It has had several key audiences—academics and researchers, public policymakers, and members of the community, particularly transgender people and our families."[4]

Valid criticism has been made of estimates of transgender suicidality. For example, data like that from the U.S. National Transgender Survey are based on a "convenience sample" of online volunteers, a method which does not produce a representative sample of the population.

The 2015-2016 California Health Interview Survey, which *was* a representative survey, found, "Transgender adults were nearly six times more likely to report having ever attempted suicide … (22 percent versus 4 percent)"[5]—a rate still much higher than the general population, but well below the often-cited 41 percent in the NTDS.

Hacsi Horváth, an expert in clinical epidemiology, a lecturer at the University of California, San Francisco, and a former transgender person who "detransitioned" (that is, returned to identifying with his biological sex) points to a similar survey of adolescents. The survey did not explicitly ask respondents whether they identified as transgender, but it did identify a population who were "highly gender non-conforming," which could be used as a proxy for transgender status. Among this group, only 3% of girls and 2% of boys reported having attempted suicide.[6]

"Suicidality" vs. Suicide

There is one factor about data like those above that in one sense is obvious but is nevertheless often overlooked. None of those statistics look at *actual* suicides. All of the data come from surveys of living transgender people, but people who have committed suicide are incapable of answering surveys.

Instead of looking at "suicide," surveys only measure "suicidality"—thoughts or behaviors which *may* lead to suicide, but *usually do not*. These measures may include:

- "Suicidal ideation" (that is, *thinking about* the possibility of committing suicide);
- Suicide "planning" (considering how, when and where one might commit suicide);
- Suicide "attempts" (which may be spontaneous or planned, may not result in serious injury, and in some cases, may be an effort to gain attention rather than actually to end one's life);
- Serious suicide attempts (resulting in life-threatening injury or injury serious enough to require hospitalization).

The frequency of each of these distinct measures of "suicidality" generally declines as one goes down the list. While every expression of suicidal thoughts or behaviors should be taken seriously, it is most important to remember that general statistics on suicidality show that only a small percentage of people who think or talk about committing suicide ever do so. For example, CDC data for 2020 indicates that only one in every 265 people who *considered* suicide actually *committed* suicide.[7]

"Stigma" or Social Support

While the data indicate that transgender-identified individuals may have higher levels of suicidality (or even of completed suicides), any steps to prevent suicidal feelings, thoughts, plans or attempts must hinge on a determination of their cause.

Rather than scientifically exploring multiple possibilities, however, activists tend to offer a single, simplistic answer for the high rates of both mental illness and suicidality among those who identify as lesbian, gay, bisexual or transgender. Using what is sometimes called "minority stress theory," they claim that societal discrimination, or "stigma," is the cause. This claim, however, has never been empirically verified.

If mental health problems among those who identify as LGBT were caused by "discrimination," one would expect that they would be much more severe in places with higher levels of discrimination, and much less severe in places where LGBT identities are widely accepted. However, this is not what the research shows.

With respect to homosexuality, for example, one study has identified what it called the "Dutch paradox":

> "Despite the Netherlands' reputation as a world leader with respect to gay rights, homosexual Dutch men have much higher rates of mood disorders, anxiety disorders and suicide attempts than heterosexual Dutch men."[8]

The NTDS study, which produced the "41%" number cited above, was clearly designed to suggest that discrimination leads to negative mental health outcomes such as suicide attempts. However, a different study of 392 male-to-female and 123 female-to-male transgender persons in San Francisco found similar mental health problems among transgender people, even though such identities are highly accepted there. In both the male-to-female and the female-to-male groups in the San Francisco study, 32% reported that they had attempted suicide.[9]

Parental Support

Pressure is particularly placed upon parents to be fully affirming of a transgender child's desire to be recognized as another gender identity. Parents are often explicitly threatened that if they do not unquestioningly accept and fully affirm their child's gender confusion, the child will commit suicide. For example, a therapist will ask parents of a biological male, "Would you rather have a dead son or a live daughter?"[10] Although some studies have purported to show mental health benefits to children supported in a "gender transition"[11] by their parents, the methodology of these studies has also been widely criticized, calling the validity of their conclusions into question. Michael Bailey and Ray Blanchard, both Ph.D.s, concluded, "It serves … parents poorly to exaggerate the likelihood of their children's suicide, or to assert that suicide or suicidality would be the parents' fault."[12]

Co-founder of Advocates Protecting Children Maria Keffler puts her critique more strongly:

> Nothing about that guidance is supported by research, data, or long-understood principles of child development, but this emotional manipulation coerces parents like the thumbscrews of a torture device, terrorizing them with the idea that unless they capitulate to the transgender industry's demands, they will inevitably lose their child.[13]

Gender Transition Medical Treatments Do Not Improve Mental Health

Before examining the specific evidence regarding suicide, it makes sense to examine the broader question of mental health in general. An obvious but often unspoken reality about gender transition medical interventions is that their *only* purpose is to improve a patient's *mental* health. There is no benefit to one's *physical* health from blocking normal puberty, administering cross-sex hormones, or amputating healthy body parts.

Evidence suggests that these procedures do little to improve a patient's overall mental health, and certainly do not bring it to the level of the general population. Johns Hopkins University was the first American medical center to venture into "sex-reassignment" surgery. But under the leadership of Dr. Paul McHugh, they undertook a study in the 1970s to examine the outcomes for transgender people who had surgery. Dr. McHugh explained why Johns Hopkins subsequently stopped doing "sex-reassignment" surgery:

> I concluded that Hopkins was fundamentally cooperating with a mental illness. We psychiatrists, I thought, would do better to concentrate on trying to fix their minds and not their genitalia.

> … We have wasted scientific and technical resources and damaged our professional credibility by collaborating with madness rather than trying to study, cure, and ultimately prevent it.[14]

In 2016, the Centers for Medicare & Medicaid Services (CMS) declined to issue a "National Coverage Determination" that would mandate coverage for such surgery under Medicare, declaring that "there is not enough high quality evidence to determine whether gender reassignment surgery improves health outcomes." CMS examined 33 studies but found that all had "potential methodological flaws," and that "[o]verall, the quality and strength of evidence were low." Patients in the best studies "did not demonstrate clinically significant changes" after surgery.[15]

In a 2020 article, Dr. McHugh described results from another review of the literature:

> After reviewing 21 studies, the Hayes Directory concluded that the studies "were inconsistent with respect to a relationship between hormone therapy and general psychological health, substance abuse, suicide attempts, and sexual function and satisfaction." For quality of life, "[d]ifferences between treated and untreated study participants were very small or of unknown magnitude," suggesting little evidence of effectiveness.
>
> Alarmingly, and contrary to the popular narrative, the Hayes Directory reports that the studies show the prevalence of suicide attempts was not affected by hormone therapy.[16]

Dr. Miroslav Djordjevic is one of the world's premiere genital reconstruction surgeons, and he has performed gender "reassignment" surgery. However, even Djordjevic has begun encountering more and more transgender patients who regret their surgery and seek to "detransition."[17] Dr. Djordjevic confirms "crippling levels of depression" in his patients and some who have contemplated suicide.

Do Gender Transition Procedures Prevent Suicide?

Transgender activists often argue that "social support" or "affirmation" of a person's gender identity is not enough to prevent suicidality. They insist transgender individuals, including minors, must be afforded the opportunity to undergo cross-sex gender transition medical procedures—again, because they allegedly will be at higher risk of suicide if these procedures are not provided.

Such interventions may include puberty-blocking drugs for pre-pubescent children. These usually lead to the administration of cross-sex hormones and then to surgical procedures such as removal of the male genitals as well as mastectomies and hysterectomies for girls. These surgical procedures cause permanent, irreversible infertility,[18] and often a loss of sexual function for the individual as well.[19]

In a journal article, Sahar Sadjadi, a professor at Canada's McGill University, summarizes the arguments used to support the use of puberty blockers in transgender-identifying children:

> [A] core argument for puberty suppression is frequently repeated by numerous clinicians and advocates of the treatment: preventing the body from developing unwanted secondary sex characteristics saves children from violence, suicide, self-harm, and mental illness at the onset of puberty … and from violence and discrimination (and in some accounts, unemployment, drug use, prostitution, suicide) which besets … transgender adulthood.[20]

In support of this theory, a 2020 study by Jack Turban, et al. in the journal *Pediatrics* claimed to have found evidence that suicide risk could be lowered by giving puberty suppression treatments to youth who want them.[21] Though widely touted in the news media, the claim does not really seem to be supported by the study itself.

Using only subjective, self-reported outcome measures, the authors singled out one of these, suicidal ideation, and said that "those who received treatment with pubertal suppression, when compared with those who wanted pubertal suppression but did not receive it, had lower odds of lifetime suicidal ideation."

However, statistics regarding rates of "lifetime suicidal ideation" or "lifetime suicide attempts" for trans-identifying individuals do not necessarily prove anything about the causal effect of particular interventions. Critical to any meaningful interpretation is understanding whether suicidal feelings, thoughts, plans or attempts occurred before, during or after medical interventions. The transgender-affirming GLMA (formerly the Gay and Lesbian Medical Association) has acknowledged, "Suicide is a risk, both prior to transition *and afterward*" (emphasis added).[22]

The authors of the *Pediatrics* article admitted that "it is plausible that those without suicidal ideation had better mental health when seeking care and thus were more likely to be considered eligible for pubertal suppression."[23] A pediatrician who critiqued the study noted that even those youth who received puberty suppression had significantly higher than average rates of suicidal thoughts (75%) and attempts (42%). He concluded, "The prevailing narrative that these interventions are necessary to prevent suicide is without reasonable evidence."[24]

Other studies focusing on transgender adults have also shown that alarming rates of suicide persist even in those who have undergone medical gender transition procedures. A prominent 2011 study in Sweden followed more than 300 transgender surgery patients for up to 30 years and concluded: "Persons with transsexualism, after sex reassignment, have considerably higher risks for mortality, suicidal behavior, and psychiatric morbidity than the general population." The study found that 10 years after cross-sex surgery, suicide rates were nearly 20 times that of the general population.[25]

Another study using data from Sweden, published online in October 2019, found that utilization of mental health services (including "hospitalization after suicide attempt") declines with time after so-called "gender-affirming" surgery. The authors concluded that this was evidence that such surgery is beneficial.[26] However, criticism of the study led to a re-analysis of the data, directly comparing those who had received surgery with those who had not. This analysis

showed *no* benefit from surgery, leading the authors to publish a correction and admit that their original positive conclusion "was too strong."[27]

After a U.K. review of more than 100 international medical studies of post-operative transgender persons, Christopher Hyde, director of the University of Birmingham's Aggressive Research Intelligence Facility, warned, "There's still a large number of people who have the surgery but remain traumatized—often to the point of committing suicide."[28]

Could Gender Transition Procedures Actually *Increase* Suicide?

There is at least some evidence that gender transition medical procedures may *increase* rates of suicide, not decrease them.

Anecdotal evidence of this point can be found in a 2018 op-ed by Andrea Long Chu in *The New York Times*. Chu was preparing for gender "reassignment" surgery—but bluntly debunked much of what is often claimed for such cross-sex hormones, including the assertion that they reduce suicidality, declaring, "I was not suicidal before hormones. Now I often am."[29]

In the 2020 *Pediatrics* article by Turban, et al., on four of the nine mental health outcome measures—nearly half—the outcomes for those who received puberty blockers were worse than for those who did not. Most of these differences were small, but one was dramatic. Those who received puberty blockers were *twice as likely to have had a suicide attempt resulting in inpatient care (i.e., hospitalization) in the last 12 months* as those who did not (45.5 percent vs 22.8 percent).[30]

It is also important to compare the outcomes in the study with the probable outcomes in the long term among gender dysphoric children who would *not* go on to a gender transition. A Norwegian neuroscience professor examined the *Pediatrics* study on puberty blockers and suicidality and explained:

> Of 1000 children with GD [gender dysphoria], if all receive puberty suppression then we expect all 1000 to go on to full transition whereas without the pubertal inhibition only 150 (15% of 1000) will transition. As the authors correctly state in the paper, 40% of transpersons attempt suicide in a lifetime, which means that with PB [puberty blocker] administration to all, we expect 40% of 1000 = 400 persons to attempt suicide. The authors show, however, that because of the benefits of PB, this may perhaps be adjusted downward by a factor of 0.6; the expected outcome is then 240 attempted suicides. In contrast, if none of the 1000 subjects receive puberty suppression then only 60 persons (40% of 150) are expected to attempt suicide."[31]

Thus, widespread use of puberty suppression could increase rather than decrease suicide risk.

A 2022 study by Jay Greene of the Heritage Foundation takes a unique approach to studying the question of whether "gender-related medical interventions" might reduce suicides among young people. Greene acknowledges, "The research presented here does not directly examine whether the individuals who receive gender-related medical interventions are at a higher risk of suicide."

Using various proxy measures, however, Greene found that as interest in gender transition procedures has grown in recent years, youth suicide rates have *increased* in states that make it easier for minors to access medical care without parental consent, relative to the rates in states without such provisions.[32]

Regarding the 2011 Swedish study of post-surgical patients, the U.S. Centers for Medicare & Medicaid Services asserted that "we cannot exclude therapeutic interventions as a *cause* of the observed excess morbidity and mortality" [emphasis added].[33]

Meanwhile, the re-analysis of the 2019 Swedish study found that hospitalizations after suicide attempts in the one year examined (2015) were nearly twice as high in the surgery group as in the non-surgery group.[34]

In other words, so-called "affirming" medical interventions, including hormone therapy and surgery, have not been shown to reduce the risk of suicide for those who identify as transgender. Moreover, cross-sex medical interventions may cause harm and *increase* suicide risk instead.

Underlying Mental Illness

Experts on suicide in general note, "Untreated mental illness (including depression, bipolar disorder, schizophrenia, and others) is the cause for the vast majority of suicides," noting, "Over 90 percent of people who die by suicide have a mental illness at the time of their death."[35]

This suggests that looking outward (at family and society) for the causes of transgender suicidality may be misguided, and a look inward (at the individual's underlying mental health) might be more important.

It is well established that there is a strong *correlation* between gender dysphoria and other forms of mental illness or psychological distress. But transgender activists vigorously resist any effort to examine whether there might be *causal* relationships. It is possible that mental illness could cause gender dysphoria, that gender dysphoria could cause other mental illnesses, or that the two could be inherently (not just coincidentally) linked.

Yet any such theory is simply ruled out in advance by proponents of transgender-"affirming" interventions. It is inconsistent with their ideological paradigm, which says that transgender people are "born that way" and that being transgender is perfectly normal and harmless (except for having the "wrong" body and facing a hostile social environment, that is).

This paradigm may serve the transgender political agenda, but ironically it may not serve transgender individuals well. It prevents them from getting treatment for the actual problems which may underlie their feelings of gender incongruence and/or suicidality.

Authorities in Europe are beginning to recognize this and take action to ensure that a proper focus is placed on treating underlying psychiatric conditions. A preliminary report from Sweden's National Board of Health and Welfare (as translated and quoted with emphasis by the *Canadian Gender Report*) said:

> *People with gender dysphoria, especially young people, have a high incidence of co-occurring psychiatric diagnoses, self-harm behaviors, and suicide attempts* compared to the general population. Co-occurring *psychiatric diagnoses among people with gender dysphoria are therefore a factor that needs to be considered more closely* during investigation. Suicide mortality rates are higher among people with gender dysphoria compared to the general population. At the same time, people with gender dysphoria who commit suicide have a very high rate of co-occurring serious psychiatric diagnoses, which in themselves sharply increase risks of suicide. Therefore, *it is not possible to ascertain to what extent gender dysphoria alone contributes to suicide, since these psychiatric diagnoses often precede suicide*."[36]

Suicide Threats as Manipulation

We must stress that every suicide threat or expression of suicidal feelings should be taken seriously, and counseling or other mental health interventions should be always pursued when they occur.

However, it would be irresponsible not to recognize, especially in the current environment of socio-political polarization over transgender issues, that threats or warnings of suicide—from transgender individuals, or from professionals and politicians—may also be used as a form of manipulation to achieve a desired personal or political outcome.

There is certainly anecdotal evidence of this. The well-known (and openly gay) writer Andrew Sullivan wrote about meeting with detransitioners who had formerly identified as transgender. One confessed to him, "I threatened my parents and friends with suicide. It became part of my identity to be suicidal. I screamed at my parents about this, even though I knew I wasn't going to kill myself."[37]

One doctor in the field has even recommended this as a strategy. According to a report about a forum in Vancouver, Canadian psychologist Wallace Wong was recorded on video recommending to youth that they threaten suicide if necessary: "So what you need is, you know what? Pull a stunt. Suicide, every time, [then] they will give you what you need," Wong said, adding that gender-dysphoric kids "learn that. They learn it very fast."[38]

Experts Michael Bailey and Ray Blanchard give a more detailed explanation of "false" reports of suicidality:

> 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.[39]

Detransitioner Hacsi Horvath notes how the "suicide threat" is used by activists and clinicians—not just transgender youth and adults themselves:

> In contrast, every type of medical or social intervention for the supposed benefit of people with GD, especially youth, is described as "life-saving." The refrain of "life-saving" echoes everywhere in the discourse around this topic. This has been a key strategy in convincing people that major surgeries are a "medical necessity" – "the basic healthcare they need to survive." According to the trans industry and its friends, spikes in GD due to transphobia seem to lead almost automatically to AYA-GD wanting to end their lives. It is as if they are always on a ledge, ready to jump. This incessant repetition of purported suicide risk is like a strange new variation of Munchausen syndrome by proxy, wherewith trans activist adults and some clinicians effectively threaten suicide on behalf of the young people. They do this to socially-engineer, manipulate and intimidate non-industry doctors, politicians, community leaders and families of AYA-GD. They are well aware of the emotional responses they will get with this rhetoric.

Horvath notes that this may not be in the best interest of transgender people themselves since "experts in suicide prevention have always recommended against strongly emphasizing suicide risk in a given population."[40]

Conclusion

Every suicide threat—particularly from a child or adolescent—should be taken seriously.

However, the claim that affirmation of a transgender identity—both socially and with invasive medical procedures—is the only way to prevent suicides is *not* supported by the evidence. Rates of reported suicidality among transgender-identified individuals remain high even among those who live in affirming communities and who have received gender transition medical interventions. There is no compelling evidence showing that social affirmation or cross-sex medical interventions for trans-identifying persons will improve their mental health or reduce this risk of suicide, and there is some evidence that such affirmation or interventions may increase that risk.

These findings have significant policy implications. Increasingly, legislatures and policymaking bodies across the world are being required to grapple with what could appropriately be called "forced-affirmation" legislation or policies. These well-meaning but ill-advised forced-affirmation mandates seek to force all persons to collude with and "affirm" the confused mental state of trans-identifying persons and can include:

- Mandates forcing the use of cross-sex or newly created pronouns when referring to trans-identifying persons. (The New York City Commission on Human Rights recognizes 31 different genders,[41] and a person can be fined up to $250,000 for knowingly "misgendering" a person by referring to them according to their biological sex instead of using their preferred pronoun.[42])

- Mandates requiring the placement of trans-identifying persons in prison cells or shelters that do not correspond with their biological sex. (A number of such placements have

resulted in rapes of female inmates and even pregnancy.[43])

- Mandates requiring parents to "affirm" their child's wrong-sex identity and to facilitate the administration of puberty blockers or cross-sex hormonal interventions or surgeries to their trans-identifying child or potentially lose custody. (A tragic example of this was the 2019 suicide of a 16-year-old girl who was affirmed by her school in the wrong sex and was placed in foster care to facilitate her gender transition, despite the strong protests of her mother.[44])

- Mandates requiring female sports teams to allow males who identify as women to compete on their teams.[45]

- Mandates allowing trans-identifying biological males unfettered access to and use of girls' showers, locker rooms and bathroom facilities.[46]

And while opposition to "forced affirmation" policies has largely been based on the harm such policies can do to the persons who are forced to affirm transgender identities, the evidence presented in this brief shows that sadly, such forced affirmation policies may harm the very people they are designed to help. Such policies may lead to more suicidality, not less.

No one—whether a parent, politician, or citizen—should be manipulated by the misleading claims that colluding with a fantasized alternative gender identity that is alien to a person's biological sex will protect them from committing suicide. Indeed, the very opposite may be true.

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[7] The Centers for Disease Control and Prevention (CDC) reports, "In 2020, an estimated 12.2 million American adults seriously thought about suicide, 3.2 million planned a suicide attempt, and 1.2 million attempted suicide."

The number of Americans who died by suicide that year was 45,979. See: Centers for Disease Control and Prevention. (2022, May 24). *Facts about suicide.* https://www.cdc.gov/suicide/facts/index.html

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[11] "Gender transition" is the process whereby a person goes from publicly identifying with his or her biological sex to publicly identifying with a psychological "gender identity" different from that (often, but not always, identifying with the opposite sex). Gender transition can be limited to a "social transition" (changing name, pronouns, clothing, and hair style, without any physical change to the body), or it can encompass a "medical transition" (which may involve the use of puberty-blocking drugs, cross-sex hormones, or "gender reassignment surgery" to alter the appearance and sex-related physical characteristics of the body).

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[19] Even Marci (formerly Mark) Bowers, a surgeon who *is* transgender, has expressed concern about this. See: Emmons, L. (2022, May 1). 'Gender affirming' surgeon admits children who undergo transition before puberty NEVER attain sexual satisfaction. *The Post Millennial.* https://thepostmillennial.com/gender-affirming-surgeon-admits-children-who-undergo-transition-before-puberty-never-attain-sexual-satisfaction

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