When the Data Make Us Uncomfortable

An Old Psychologist's Plea for Open Debate and Informed Consent

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A Tragedy That Should Make Us Pause

The recent tragedy in Canada has weighed heavily on me. Whenever children lose their lives in acts of violence, something in all of us should pause. As clinicians, as parents, as citizens, we owe it to the victims and their families not only to grieve, but to examine honestly the conditions that surround such events. Silence may feel safer. But careful inquiry is the deeper form of respect.

I write this not as a partisan, not as an activist, and not as someone looking to score points in a cultural argument. I write this as a psychologist who has spent decades sitting across from suffering human beings, including adolescents presenting with gender dysphoria and their families, and who believes that good medicine must never be afraid of honest questions.

The Spirit in Which This Is Written

Before going further, I want to acknowledge clinicians I respect deeply, including Dr. Josef Witt-Doering and other endocrinologists and psychiatrists who have dedicated their lives to alleviating suffering. These are not reckless individuals. They are thoughtful physicians who entered medicine to help vulnerable patients.

Dr. Witt-Doering has raised concerns about insufficient informed consent and about serious adverse outcomes that, in his view, are not always fully acknowledged. He is not anti-medication. He prescribes when appropriate. But he advocates slowing down, fully informing patients of risks and unknowns, and carefully tapering when medications destabilize.

This essay is written in that same spirit: not to condemn, not to inflame, but to invite reflection where certainty has become culturally accelerated.

The Complexity We Cannot Ignore

This is not an attack on transgender-identified individuals. It is not a dismissal of the profound distress many young people experience as they struggle with identity, belonging, and coherence.

In my experience, adolescents presenting with gender dysphoria frequently carry layered burdens that predate and exceed questions of gender alone: trauma histories, sexual abuse, attachment disruptions, autism spectrum traits, depression, anxiety, loneliness, immersion in social media ecosystems, exposure to pornography, and fragile or diffuse identity formation.

In clinical reality, these underlying psychiatric and developmental vulnerabilities are far more prevalent and far more predictive of long-term instability than medication side effects alone. That weighting matters.

When young people present with that degree of vulnerability, depth should precede decisiveness. Time should precede irreversibility. Curiosity should precede certainty.

Yet many families increasingly hear that the science is settled. Careful reading of the literature, however, reveals small samples, short follow-up periods, high attrition rates, limited controls, and heavy reliance on self-report measures. Rare adverse outcomes are difficult to detect in small cohorts. Short-term improvements do not automatically translate into long-term stability.

These are methodological realities, not ideological accusations.

The Questions Raised by Emerging Data

There is also a broader societal pattern that deserves sober examination. Dr. Witt-Doering recently compiled a dataset of 16 qualifying U.S. K–12 school shootings over a defined period, identifying four perpetrators described in media accounts as transgender-identified or nonbinary.

Four cases do not establish causation. Small numbers demand caution. But when a demographic estimated to represent a small percentage of the youth population appears in a quarter of a defined dataset, further study is not unreasonable.

If there is no disproportionality, rigorous analysis will clarify that. If complexity emerges, we must examine it without scapegoating and without denial.

Asking the question is not accusation. It is inquiry.

Medication, Vulnerability, and Vigilance

Adolescents presenting with gender dysphoria experience elevated rates of depression, suicidality, and comorbid psychiatric diagnoses. Many are prescribed psychotropic medications during adolescence — a period of significant neurological development.

Antidepressants carry FDA black-box warnings regarding increased suicidal ideation in a subset of youth. That alone warrants sober informed consent. At the same time, it must be stated clearly: the overwhelming majority of young people who take antidepressants do not become violent. Underlying psychopathology — trauma, mood disorders, neurodevelopmental conditions — is far more prevalent than rare medication-induced behavioral activation.

Still, respected clinicians including Dr. Josef Witt-Doering and others have raised concerns that, in uncommon but serious cases, certain psychotropic medications may contribute to behavioral activation, akathisia, severe agitation, or impaired impulse regulation. These concerns remain debated. They are not established as population-wide causation. But controversy is not irrelevance.

When layered vulnerabilities are present, vigilance is not alarmism. It is responsibility.

Hormonal Interventions and Developmental Unknowns

Hormonal interventions likewise alter endocrine systems that directly interact with mood regulation, stress physiology, impulse control, and long-term reproductive development.

Particularly in adolescents, supraphysiologic cross-sex hormone exposure may introduce neuroendocrine instability. Emerging concerns include mood volatility, irritability, altered libido, emotional lability, fertility implications, bone density changes, and long-term metabolic consequences. In youth with preexisting trauma histories or neurodevelopmental vulnerabilities, these effects may compound existing instability.

Again, this is not an argument for prohibition. It is an argument for longitudinal humility.

What we do not yet possess are robust, multi-decade studies examining how early hormonal intervention, psychiatric comorbidity, trauma exposure, medication interaction, and identity development unfold across time.

Could early biological intervention destabilize certain vulnerable adolescents?
Could medication activation exacerbate dysregulation in rare cases?
Could layered vulnerabilities, under specific circumstances, compound risk?
We do not know.

And not knowing requires study — not silence.

A Plea to My Colleagues and to My Readers

My fellow clinician.
My fellow parent.
My fellow citizen.

Looking away may feel easier. It spares us conflict. It spares us discomfort. It spares us criticism. But when children die, when young people suffer, when developmental vulnerability meets powerful biological intervention, looking away carries its own burden. Compassion and scrutiny are not enemies. They are partners. One without the other becomes either cruelty or carelessness.

To protect transgender-identified individuals from cruelty is right.
To protect vulnerable adolescents from premature certainty is also right.
To expand informed consent rather than narrow debate is not aggression; it is integrity.

If we refuse to reflect because reflection is uncomfortable, we drift away from the humility medicine requires.

So let us not look away.
Let us grieve deeply.
Let us study carefully.
Let us speak honestly.
Let us love fiercely.

And let us be brave enough to look — not with accusation, not with ideology, but with compassion, discipline, and the quiet courage that good science and good conscience require.