Elective Affinities?* Trans-Identification and Anorexia Nervosa as Maladaptive Attempts to Resolve Developmental Conflicts in Female Adolescence

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Wahlverwandtschaften? Trans-Identifizierung und Anorexia Nervosa als maladaptive Lösungsversuche für Entwicklungskonflikte der weiblichen Adoleszenz

Abstract

The number of minors who believe they are „the wrong gender" and seek sex reassignment has increased exponentially in recent years. It is striking that over 80 percent of affected gender dysphoric adolescents who wish to undergo body modification procedures and legal measures are now girls. The draft of the so-called „Self-Determination Act" (Self-ID) stipulates that minors who have reached the age of 14 should be able to submit a corresponding application to the relevant registry office without any preconditions. In view of this, it is all the more important to analyze the causes of the observed epidemiological shifts. Above all, it must be critically reflected whether transgender identification might also be a maladaptive solution strategy for quite a few adolescent girls to avoid the pressure from the significant developmental tasks and adjustment requirements of female puberty. In order to gain a deeper understanding of this point, it is helpful to look at the analogies between a newly occurring gender incongruence that first manifests itself in early or middle adolescence and anorexia nervosa, and to work out the underlying developmental psychological causes of female puberty and adolescence in particular. Based on this, and following a brief discussion of different approaches to the treatment of gender dysphoric children and adolescents, possibilities for medical prevention are presented.

Keywords: Female puberty, Body dysphoria, Anorexia nervosa, Gender incongruence, Transsexuality, Self-Determination Law

Zusammenfassung

Die Anzahl von Minderjährigen, die sich „im falschen Geschlecht" wähnen und eine „Geschlechtsänderung" anstreben, ist in den letzten Jahren exponentiell gestiegen. Dabei sticht ins Auge, dass mittlerweile über 80% der betroffenen gendersdysphorischen Jugendlichen mit Wunsch nach körpermodifizierenden und juristischen Maßnahmen Mädchen sind. Der Entwurf des sog. „Selbstbestimmungsgesetzes" sieht vor, dass auch Minderjährige mit Vollendung des 14. Lebensjahres voraussetzungslos einen Antrag auf Personenstandsänderung beim zuständigen Standesamt sollen abgeben können. In Anbetracht dessen gilt es umso mehr, die Ursachen für die beobachteten epidemiologischen Verschiebungen zu analysieren. Kritisch reflektiert werden muss vor allem, ob die transgeschlechtliche Identifizierung für nicht wenige jugendliche Mädchen eine maladaptive Lösungsstrategie sein könnte, dem Druck durch die immensen Entwicklungsaufgaben und Anpassungserfordernisse der weiblichen Pubertät auszuweichen. Um in diesem Punkt zu einem tieferen Verständnis vorzudringen, ist es hilfreich, die Analogien einer sich in der Adoleszenz erstmanifestierenden Genderinkongruenz und der Pubertätsmagersucht in den Blick zu nehmen und die dem zugrunde liegenden entwicklungspsychologischen Ursachen speziell der weiblichen Pubertät und Adoleszenz herauszuarbeiten. Ausgehend davon werden, nach vorangestellter Diskussion unterschiedlicher Ansätze in der Behandlung von geschlechtsdysphorischen Kindern und Jugendlichen, Möglichkeiten ärztlicher Prävention aufgezeigt.

Schlüsselwörter: weibliche Pubertät, Anorexie, Körperdysphorie, Geschlechtsinkongruenz, Transsexualität, Selbstbestimmungsgesetz

Introduction

The idea that adolescence is the best time in one's life can only have arisen from the hazy rose-tinted memories of adults. Never again will the individual, especially the female, feel so alienated in her own body, and never again in one´s life will a person have to deal with such a **wealth of radical changes** as during puberty. The aim and tasks of puberty and adolescence are to integrate the body and as it changes due to maturation, to build intimate rela-

* The original german title *Wahlverwandtschaften* (E*lective affinities*, also translated under the title *Kindred by Choice*) refers to a novel by German writer and polymath Johann Wolfgang Goethe (1749–1832), published in 1809. The text itself is a translation from the German, the original was published in the journal listed below.

Aspects of psychosexual and identity development

- Consolidation of a new body identity and ego integration of the changing body in the course of puberty; consolidation of the gender-related sense of belonging
- Examination of the individual sexual preference structure that manifests itself under the influence of (native) sex hormones during puberty
- Shaping sexual relationships and developing one's own sexual identity on the basis of age-appropriate sociosexual experiences
- Autonomy/detachment from parents, relativization of the influence of the family of origin and definition of one's own attitudes, evaluation categories, and values
- Develop realistic career plans and life plans as well as suitable strategies for positioning themselves among their peers

tionships, develop fertility and the ability to reproduce, identity, independence, social competence, and realistic prospects for the future. These processes touch on all the detours, longings. and fears in human existence. On the one hand, this requires resilience, assertiveness and great **willingness to change.** On the other hand, successfully traversing adolescence also requires **flexibility** and advanced **emotional and self-regulation skills**.

This article is not only aimed at child and adolescent psychiatrists and therapists. It also calls on all physicians who are in contact with adolescent patients, including those who work in pediatric and primary care (in hospitals or outpatient settings), to become aware of the specific challenges and problems associated with female puberty and to make even more efficient use of the possibilities of medical-therapeutic counselling, support and sex education for the prevention of age-typical mental disorders in the future.

After an introductory overview of the psychological changes and physiological brain maturation processes that take place during puberty, the central developmental tasks of female adolescence and the difficulties that often accompany them are discussed. These are, on the one hand, the necessary **consolidation of a new body identity** and, on the other, the shaping of sexual relationships, including **the development of the ability to experience sex**. In comparison, both the ego integration of the puberty-related changing body and the process of finding a sexual identity and consolidating one's own desire differ in some respects. The necessary developmental steps are particularly challenging for girls.

Secondly, **evident similarities between gender dysphoria and anorexia nervosa** are discussed, which include the fact that both are body dysphoric disorders directly connected to sexuality, and that both can be understood as **maladaptive coping strategies** for a subjective experience of feeling overwhelmed during adolescence, which occurs much more frequently in female adolescents.

Thirdly, these primarily developmental psychological considerations can broaden our perspective on the **ongoing controversy surrounding different treatment approaches** for the care of children and adolescents with gender-related identity conflict (gender dysphoria) and the advantages of *gender-critical* or *gender-exploratory* therapy over *transaffirmative* therapy that we believe are crucial. In addition, possibilities and starting points for medical prevention are shown.

Puberty Moratorium

Developmental tasks, brain maturation processes and stumbling blocks

Until a few years ago, it was commonly held that the typical behaviors of adolescents during puberty and adolescence were primarily due to the effects of specific sex hormones. There is now consensus, that hormones and **directed remodeling and reorganization processes of the brain** interact in a unique way during this time (Giedd et al., 2012). The maturation of the brain proceeds from "back to front," so to speak, from simpler to higher functions, i.e., not all brain regions mature at the same time or at the same speed. Perception, movement control, and spatial and temporal orientation or the sleep-wake rhythm are readjusted, albeit often inefficiently, and finally the prefrontal cortex, which is responsible for planning, deliberation, considered decisions, level-headedness, and impulse control, matures (Krone, 2011). Certain behaviors and temporary impairments are – with individual differences – equally typical of puberty in both genders:

- Emotional fluctuations and difficulties regulating emotions
- Alternating feelings of superiority and inferiority
- Identity and role insecurity, shyness, "Shame crisis"
- Limited ability to plan and act with foresight
- Lack of sense of danger, risky and reckless behavior
- Egocentrism and rebellious behavior, "physiological narcissism"

Adolescents seek out new experiences, the consequences of which cannot always be properly considered and the risks of which temporarily cannot be correctly assessed – **many of the confusions of puberty can be explained by this sequence of brain maturation processes.** However, puberty is also a time when the feelings and behavior of adolescents towards their parents can be particularly contradictory, as **individuation and detachment from primary caregivers**, the reshaping of object relationships, the

relativization of the influence of the family of origin and the development of one's own standards of judgement and decision making are considered essential developmental tasks of adolescence.

It is also important and appropriate for parents to assert their own opinions, re-inforce rules and sometimes firmly say "no". A parental laissez-faire-attitude can be particularly hurtful for young people in the difficult phase of puberty; they require certainty and need to experience boundaries – if only to rally notice when they have reached or crossed a boundary. **Crossing boundaries and breaking taboos** can be quite pleasurable experiences during puberty and these are necessary in order to explore one's own scope for action and its limits. This is only possible if boundaries are set in the first place.

Special problems of female adolescence – depressive self-concept

In the many years in which we have provided our medical expertise additionally to school and parental sex education – through dedicated girls' consultation hours implemented for this purpose and tailored to the questions and special needs of female adolescents, or as part of a medical-therapeutic consultation and treatment – female adolescents have always responded to this offer of information and support with great interest. On the other hand, they have also repeatedly revealed a **depressive self-concept and insecurities in body perception**, which are typical of female adolescence and occur frequently (Fig. 1)[1] It is noteworthy that this applies equally to the non-clinical sample of schoolgirls and to manifestly mentally ill adolescent girls in need of treatment, albeit with different frequencies and severity.

When an estimated 1/3 of the girls during the past school year told us what they would wish from a fairy godmother was, "I would rather be a boy" (see Fig. 2) – a response we have rarely encountered in such decisive terms in recent years – this desire cannot be explained in isolation from the **current media spotlight on transgender issues.** How else could the dramatic increase in the number of cases especially among female adolescents, be understood without pointing out the negative impact of influencers who promote a supposedly easy and risk-free "transition" in social networks and internet forums (Korte & Tschuschke, 2023; Korte et al., 2020)?

When asked whether this is about the desire for a penis and other primary and secondary male sexual characteristics, the majority of girls denied the wish for male genitalia or secondary sex characteristics. Instead, their focus is on the fact that being female and becoming a woman are associated with a variety of disadvantages,

- I **am 13 years old**
- My height
- My weight
- Do you feel comfortable in your body?
  - o Always
  - × Not always

  Why not? **just the way it is**
  - o Never

  Why not?
- Would you like to change something about yourself?
  - o No
  - × Yes
- What? **everything**
- If there was a fairy godmother, what would you ask her for?

  Wishing to be prettier and thinner

  A horse

Fig. 1: Depressive self-concept of a 13-year-old 2021

- **I am 14 years old**
- **My height 153 cm [about 5 ft]**
- My weight
- Do you feel comfortable in your body?
  - o Always
  - o Not always

  Why not?
  - × Never

  Why not? **would prefer to be a boy**
- Would you like to change something about yourself?
  - o No
  - × Yes

  What? **sex**
- If there was a fairy godmother, what would you ask her for?

  I want to be a boy

Fig. 2: "I want to become a boy" (2023)

[1] Figures 1–5 with scanned handwritten entries in the original German version have been replaced in the English version by a translation of the answers given by the girls.

restrictions, and excessive demands. Although there is a pronounced **rejection of the changing female body** and/or the **female gender role**, there is no pronounced desire for the physical characteristics of the opposite sex. These girls therefore *do not* meet the DSM-5 diagnostic criteria for clinically relevant gender dysphoria. Nevertheless, this presentation of symptoms often leads to misdiagnoses and prompts some clinicians to hastily refer the adolescents to gender clinics. The accompanying attention is welcomed by many insecure teenagers; they do not contradict these external attributions when they come along with the desired feeling of being taken seriously and attribute their suffering from puberty-related changes as confirmation of their self-diagnosis as "trans".

This can develop a momentum of its own, with the complete adoption of the identification template ("trans-kid") that is currently popular in society and politics. This is understandable because it provides a plausible explanation for the negative self image and body image ("born in the wrong body"). In addition, the **desire for uniqueness**, originality, and at the same time identity-forming **group membership typical of puberty** are likely to play roles in some instances of trans-identification (Korte & Tschuschke, 2023).

This extremely unfortunate course could be prevented by greater counseling competence in primary care. However, we must concede that it is not always easy to draw a clear line between the different presentations or variant expressions of puberty-related maturation conflicts. This is because there are increasingly frequent overlaps and fluid transitions, e.g., between anorexia, body dysmorphic disorder (such as the isolated rejection of the female breast) and gender dysphoria, to which we will return later.

Even most girls who are more severely affected and fully meet the criteria for gender dysphoria, there is often – and this is crucial – no evidence of a history of gender-incongruent experiences in childhood. Rather, the "trans-outing" occurred suddenly and surprisingly for the familial-social environment with the onset of puberty, apparently causally related to it, in the sense of a maladaptive reaction to the maturation-related changes perceived as stressful or overwhelming. In connection with this acutely occurring desire for transition, known as **rapid onset gender dysphoria** (ROGD) (Littman, 2018), experts sometimes speak of a **Werther effect** – analogous to the increase in suicides among young males following the publication of Johann Wolfgang Goethe's novel *The Sorrows of Young Werther*.

In order to better understand the epidemiological shifts described in detail later, it is worth examining gender-typical differences in the perception of puberty-related physical and psychological maturation processes.

Consolidation of a new female body identity

Actual and "perceived" excess weight

During puberty, the female body undergoes purposeful changes with regard to the reproductive aspect of sexuality. Nature initially creates all the prerequisites before establishing the function itself with the onset of menarche. The external signs of female sexual maturity begin with the development of pubic hair, followed by breast development and armpit hair. In addition, adipose tissue increases by 50 percent in girls during puberty and the female body becomes curvy – a principle that has been tried and tested for thousands of years to ensure the success of a pregnancy even in times of hunger, by drawing on the body's own fat. Menarche can be expected around two years after the onset of breast development and marks the end of girls' growth in height. All these maturation-related changes to the body require girls to make **considerable efforts to integrate and adapt.** In view of these enormous upheavals, one question that arises is: How do young girls' female body image and body satisfaction develop?

The term *body image* was introduced by Paul Schilder (Schilder, 1935) and defined as the *picture of our own body which we form in our mind.* Today, the term is defined more broadly and refers not only to the perception and ideas about one's own body but also to its **subjective evaluation**. The latter is largely subject to social norms, cultural influences, and contemporary **aesthetic ideals conveyed by the media**, or is at least strongly influenced by them. Many girls grow up with Barbie dolls, whose artificial figure with an extremely slim waist and equally slim hips, leaves no room for organs, let alone pregnancy. In comparison, girls generally perceive their feminized bodies as too soft, out of proportion and fat.

There are reliable data to support this finding: The KiGGS study by the Robert Koch Institute (Schienkiewitz, 2019) found that 18.1% of 936 girls between the ages of 11 and 17 were overweight or obese, 7.5% were underweight and 74.4% were of normal weight. This means that roughly one in five girls between the ages of 11 and 17 in Germany is overweight according to objective criteria. However, the KiGGS data also revealed that many girls objectively of normal weight suffer from **distorted body image**: 54.5% of 11-17-year-old normal-weight girls stated that they thought they were "a little too fat" or "much too fat". The proportion of normal-weight female teenagers who suffer **loss of self-esteem** as a result of this unrealistic body image has increased more than the proportion of those who are objectively overweight.

The social, media, and cultural influences on adolescent girls to submit – often in a self-harming way – to the dictates of the prevailing ideal of beauty and thinness (Borkenhagen, Stirn, Brähler, 2013) are evident. There is considerable pressure, especially as a result of **media hyper-sexualization.** For many women, believing in their own attractiveness is as difficult to achieve as (perfect) physical beauty itself. The unrealistic ideal of androgynous slimness and virtual beauty prevents girls from accepting their growing bodies and the symbolic meaning of these changes in terms of fertility ("I've got such a horse's ass").

Multiple studies provide evidence that a large number of adolescent girls develop massive self-doubt as a reaction to these influences: they consider themselves ugly, unattractive, and feel ashamed of certain parts of their body as a result of a disturbed self-perception. The supposed lack of body firmness due to an increase in fat, pubic hair, and menstruation are at odds with the **body cult of a society practising self-optimization** and the possibilities of body modification. As a result, the judgment of one's own physical appearance must be negative. However, if one's own body image is permanently perceived as deviating from the desired one, it may lead to a deep insecurity about one's value as a person, a persistent feeling of failure from which many women are only able to free themselves in later years – if at all.

Ideal of the closed shell

Acceptance of the changing body using the example of the external genitalia

Girls are unsure whether what they notice about themselves is normal and find it more difficult than boys to gain certainty through comparison. The fear of being different from others leaves them feeling confused and filled with self-doubt (Fig. 3). The current aesthetic ideal of the vulva is defined by taut labia majora that completely cover the labia minora. Girls have no idea that the pictures in magazines have often been edited and retouched and are unsettled by their own perceived aesthetic inadequacy. The reasons for the proven increase in **aesthetically motivated procedures on the external female genitalia** are complex. However, skimpy swimwear, the strong presence of nudity in the media and the widespread dissemination of erotic/ pornographic images in digital media and on the Internet (Korte, 2018; 2020) have certainly contributed to the development of aesthetic norms for this part of the body.

In addition, sexual practices in partnerships have diversified and oral sex is a part of the sexual repertoire for young people. The intimate shaving fad is a logical consequence, which in turn leads to new visibility of the external genitalia. "A part of the body that was previously primarily part of the private sphere – the pubic region – is now subject to a design imperative" (Borkenhagen & Brähler, 2010, 8). The male genitalia must be as large and prominent as possible, which is supported by intimate shaving, while the female genitalia must be small and prepubescent – in line with the "ideal of the closed shell" (ibid.), as can be read in advertisements for genital surgery (labia reduction surgery).

> Hi, my name is […..] and I am 14 years old.
> I've been thinking about something for a long time.
> And because I don't want to go to the gynecologist yet,
> I hope you can help me. I've noticed for a long time that my labia minora are too big. They protrude from the labia majora. I'm really worried about it and don't know what to do.
> It looks pretty disgusting. What if I want to have sex with a boy and he is disgusted by it? Will it go away or is it always like this?
> Please help.

Fig. 3: "My labia minora are too big"

Menstruation – a gift, a necessary evil or an imposition?

Changes in the *internal* female reproductive organs remain hidden from the view of girls, and only very few ever have the opportunity to learn about the fascinating processes inside their bodies from a competent source. "When I told my mother that I'd had my first period, she just said 'Oh dear, now it's your turn too'."

The first menstruation is generally a strange, ambivalent event for girls: On the one hand, it is eagerly awaited by most girls, as it symbolizes growing up and a positive confirmation of belonging to the female sex. On the other hand, the period confronts girls with a **wealth of discomfort**. The associations associated with it are primarily based on a loss of cleanliness and control.

Many girls are restricted by more or less severe dysmenorrhea in their first fertile years. Restriction of movement is also a common complaint; girls feel disabled by the **loss of their childlike independent body feelings.** Premenstrual **mood deterioration, mood swings**, cravings, changes in skin appearance, introversion and social sensitivity accompany many girls during the four-week cycle – and many girls perceive their period as an imposition.

I think it is stupid that there is a period.

At the moment, I don´t want to have my period. Is there something that can be done about it?

I think it's pretty unfair, the boys don't have that.

Fig. 4: Menstrual perception of young girls

It is undisputed that the physical and emotional state before and during menstruation is perceived by every girl against the background of her knowledge and attitude. Thus, it is not surprising that many girls suppress this fundamentally vital process of their bodies due to a lack of information from competent sources and as a result have difficulty regaining their former positive, autonomous body image (Gille et al., 2010). This, in turn, sets the stage for feelings like, "Boys somehow have it easier!" to develop on the basis of this negative conditioning. Dealing with the female body in general and menstruation in particular is therefore a social learning and development process to which girls have a right in terms of **fertility awareness.**

Shaping sexual relationships

Learning to love in times of inner disorientation

Sexuality is a **basic need** of every human being for physical and sensual pleasure, closeness, intimacy, security, self-assurance and confirmation of being lovable and desirable. Puberty and adolescence are *the* life-history phases in which physicality and sexuality become central themes and during which girls ideally develop a positive, pleasurable relationship with their bodies and their femininity. With its **four aspects of meaning,** sexuality accompanies us throughout our lives, with quite different individual, gender- and **life-stage-specific importance** and/or characteristics.

Children experience the identity and relationship aspect from the very beginning; the pleasure dimension is also innate and should be accompanied by education in order to give children a positive and holistic image of sexuality.

Such education also should address the ideals of sexual autonomy, necessary boundaries, and mutual consideration. The reproductive aspect, on the other hand, only becomes relevant under the **influence of sex specific hormones** during puberty.

The sensory aspects of sexuality

1. **Identity aspect:** to experience oneself as desirable and accepted, to be loved, to be able to love someone and to develop a stable sense of self-worth as a result
2. **Relationship aspect:** being emotionally connected in a relationship with another person; feeling safe and secure and experiencing the certainty of not being alone
3. **Pleasure aspect:** sexual activity as a unique sensual experience and at the same time a physical-linguistic form of communication/ expression when together with a loved one; motivation and reward for sexual behavior
4 **Reproductive aspect:** conception, pregnancy and birth of a child, thus founding a family of one's own; these aspects are optional and time-limited opportunities (from menarche/puberty to menopause)

Sexual impulses are awakened in a gender-specific way

In contrast to girls, **boys** often attain their reproductive capacity with the **ejaculatory** before their physical development of secondary sex characteristics, i.e., the formation of a male body with pubic and armpit hair, voice and beard growth, begins. There is a direct and close connection between the increase in the male sex hormone testosterone in the blood and the occurrence of nocturnal ejaculations, **masturbatory acts**, and sexual curiosity. Boys in puberty are also delicate creatures with many confusing feelings. But for boys, the onset of puberty through ejaculatory is directly linked to the pleasure dimension of sexuality, which is often expressed in the context of masturbation and leads to a socially valued increase in potency in the broadest sense. Thus, while in boys the link between reproductive function and sexual pleasure is clear and direct, and the ability and desire for sex is almost biologically predetermined, things are more complicated for girls.

Unlike boys, **girls** reach their reproductive capacity with **menarche** after the growth spurt and only after developing female secondary sex characteristics. The female body is now attractive and is often recognized and commented on at an early age – **sexuality is discovered *in* a girl before it unfolds within her**. Girls quickly understand the connection between external attractiveness and success within the peer group, and many now display their bodies at early ages, in an adult manner, in order to signal their interest in contacts. As a result of these early conspicuous body changes, girls experience an external sexualization of their bodies that still bears little connection to their own feelings. This is because the first period as a symbol of female puberty has no real *sexual* quality, but initially directs girls' interest towards the inside of their bodies. The development of sexual intuition that is often

associated with menarche is overshadowed by the focus on a hygiene problem and a diffuse sadness due to the loss of the childlike independent body feeling. Girls therefore need more time to discover and allow sexual sensations. Female sexuality is initially shifted away from the *pleasure aspect* towards the *reproductive aspect*. In contrast, the pleasure experienced by boys during ejaculation overrides its significance as the beginning of fertility.

Girls in puberty are also curious about what love and sexuality has to offer. However, they are initially preoccupied with the **relationship aspect of sexuality,** i.e., the longing for a symbiotic love full of closeness and tenderness. Girl friendships are particularly important in this phase. The relationship with a girlfriend of the same age, with whom she shares fantasies, secrets, and tenderness is also very important for the process of detachment from the mother or parents. Having a friend as an affirming peer ensures a feeling of security. Quite a few girls go through a **homoerotic transitional stage** in early adolescence, including erotic-sexual activities. Over many successive and interwoven developmental stages, heterosexual girls later switch over to the libidinous impulses of courtship with a young man. Girls achieve this to varying degrees. The self-esteem-boosting experience of feeling desirable seduces girls from troubled families of origin in particular, as well as those who no longer have a stabilizing parental home, to accept their first sexual intercourse as a form of **psychological "adaptation" to their longing for love**, and tenderness and to mean something to someone. Some girls can also hardly escape society's inflationary approach to sex in the media, and the sexual experience of their peers is often grossly overestimated.

Many girls are irritated when boys are urged to express their feelings and needs for closeness in a way that is strongly influenced by the pleasure aspect (Fig. 5). Young men definitely understand sexuality as something independent that can be experienced separately from the relationship context. Most girls, on the other hand, cannot initially see sexuality in isolation from their feelings/relationship, which is in contrast to the messages of sex-positive feminism in the media. It must be acknowledged that cultural influences in the form of traditional gender role models with corresponding expectations, upbringing-related inhibitions, and other socialization effects also play a role here.

> How do you know that guys really love you, because many of them just want to mess with you or sleep with you.

Fig. 5: Relationship to pleasure dimension in the sexuality of young girls

Potential effects of objectification and misogynistic pornographic scripts

Nadrowski (2023), referring to D'Alberton & Scardovi (2021), recently pointed out the potentially underestimated importance of early **exposure to multimedia audiovisual pornography**, which some girls experience as disturbing and in some cases even traumatizing. Certain forms of misogynistic violence, deviance or – in extreme cases – delinquency pornography (e.g., termed "child pornography", but more accurately described as cinematic documentation of child sexual abuse) are likely to be of particular relevance here. Nadrowski argues that the increase in gender dysphoria among female adolescents since the 2000s correlates with the uncontrolled distribution and free availability of pornographic content on the Internet (Gassó & Bruch-Granados, 2021). She recommends addressing the topic directly in therapy, as well as in any online or offline contact between underage girls and adult men who approach them with abusive intentions via social media, chat rooms, and video portals. It does not seem far-fetched that the uncritical adoption and **appropriation of misogynistic sexual scripts** based on false assumptions about sexuality and gender roles can reinforce a rejection of femininity and exacerbate the fear of becoming a woman.

With regard to the different usage behavior of girls and boys, it could be argued that female adolescents consume pornography much less than do males. However, this would not account for the fact that girls are also unintentionally exposed to pornographic scripts, for example by being forwarded corresponding video clips (via email attachments, messenger services or chat apps) by boys in order to shock or shame them (Korte, 2018).

In a culture in which the understanding of sexuality is traditionally dominated by male needs and clearly recognizable tendencies to objectify women, it is not easy for girls to grow up with a healthy appreciation of sexuality. Early relationships all too often fail because of these incongruities, **discrepant expectations and needs**. In retrospect, 32% of girls rate the timing of their first sexual intercourse as too early/far too early for them (Scharmanski & Hessling, 2021). The idea that boys somehow have it better here too or find it easier is obvious: "I'd love to be a bit hornier" was how one girl expresses her deficient feeling.

Special case of sexual abuse

Split between the self and the body

In some cases, the rejection of one's own sex and gender and a desire to transition are based on real physical violence and, in particular, the traumatic experience of a **sexual assault** (Gehring & Knudson, 2005; Becerra-Culqui et al., 2018), although this does not necessarily have to be an hands-on sex offense.

Experiences of abuse can also play a role in the genesis of eating disorders. An increased incidence of sexual abuse in the medical history of those affected is less common in anorexia nervosa (ICD-10: F50.0) – least of all in the restrictive form of anorexia – but has certainly been described in patients with bulimia nervosa (F50.1). In addition, the experience of sexual assault is considered a non-specific **risk factor for the development of mental illness** in general, i.e., it is not pathognomonic; however, body-related disorders show the greatest association.

A few facts: The police crime statistics (PKS) record 15,520 cases of child sexual abuse (Sections 176, 176a, 176b, 176c, 176d, 176e StGB) reported by the police in Germany in 2022. Around 74% of these relate to girls and 26% to boys. In addition, there are 1,583 cases of sexual abuse of children and adolescents under protection and 48,821 cases of the production, possession or distribution of child and youth pornographic content.[2] These figures represent the so-called police bright field; the number of unreported cases is likely to be significantly higher.

Unsurprisingly, evidence of sexual abuse is significantly more common in the medical histories of female-to-male transsexuals, i.e. biologically female individuals, than in male-to-female transsexuals. Trans-identification occurring in such situations or in their aftermath would primarily be seen as a **trauma-compensatory reaction pattern.** In an older study of a *non-clinical* sample of adult female-to-male transsexuals, Devor found an extremely high rate of sexual traumatization: the proportion of those who had suffered one or more forms of sexual abuse was 60%, leading him to conclude that transsexualism (in those cases with such trauma) may be an extreme adaptive dissociative reaction to severe abuse experiences in childhood (Devor, 1994)

In addition to this very extreme form, there are other more subtle forms of traumatization. For example, trauma in the context of an attachment disorder as a result of a profoundly disturbed mother-child relationship may be similarly etiologically significant for development of a pronounced body image disorder and, in particular, gender dysphoria (Kozlowska et al., 2021), should at least be mentioned in passing; an exhaustive description of all forms of trauma that might be associated with gender dysphoria is beyond the scope of this article.

Would I rather be a man – or just not a woman?

Pubertal evasive maneuvers in reverse gear

Maturation-related changes to the body during puberty initially lead to a phase of deep insecurity for most girls. The **development of a stable female identity** in adolescence is highly complex, demanding, susceptible to disruption and accompanied by crises. Nowadays, female adolescents are confronted with a wide range of demands and choices of all kinds, which open up unimagined freedom for some, which they can use to develop emancipated professional and private life plans. Increased social expectations and the omnipresence of powerful women as role models in the media put other girls under undue pressure to perform and at risk of failing due to the enormous challenges and excessive demands they place on themselves.

For an increasing number of girls, the life model set for them by their chronically stressed and exhausted mothers, torn between professional and family care work, is no longer an attractive model for their own female emancipation, which also **requires necessary steps towards sexual self-empowerment**. Here too, the real problem is not the desire to actually want to be a man/boy, but rather the social pressure to conform. Growing up is particularly difficult in a society that is increasingly losing uniform values and norms, is characterized by moral inconsistencies and in which the symbolically significant female body is no longer recognized or valued. The media spotlights a way of dealing with sexuality that shows little or no respect for girls' age- and gender-specific instincts (Korte, 2018). As a result, quite a few girls feel overwhelmed by the challenges of being a woman and it is not surprising that they try to avoid it.

The desire to avoid maturation makes them susceptible to alternative preformed identification templates. Their fear of individual emancipation, which includes a critical examination of unrealistic cultural ideals of beauty and slenderness as well as internalized gender role stereotypes, they try to compensate for by **identifying with identitarian emotional collectives** and group affiliation (Korte & Tschuschke, 2023). Girls, particularly those with the traumatic experience of sexual assault in childhood are permanently struggling with the split between their selves and their female bodies.

In addition, the ability to wait patiently, postpone needs, and painstakingly work out what is desired has re-

2 https://beauftragtemissbrauch.de/fileadmin/Content/pdf/Zahlen_und_Facts/Fact_Sheet_Figures_and_Facts_on_sexual_child_abuse_UBSKM.pdf

ceived very little attention, at least in part due to the largely ad hoc satisfaction of needs in our consumer society. How are young people supposed to gain self-confidence in their own strengths and problem-solving strategies if they have not been able to learn to use these skills and strengths? This is another reason why girls who have a pronounced fear of the demands of becoming a woman may tend to look for an imaginary rather than a real solution to this developmental task. This is all the more likely to be the case when their childhood and previous life history were characterized by a difficult attachment, relationship or body history. For this highly vulnerable group of adolescents in particular, the possibility of undisturbed psycho-physical reorganization during puberty, i.e., time and space for development, is absolutely essential.

> You are so young, so young at the beginning, and I would like to ask you as best I can ... to be patient with everything that is unresolved in your heart and to try to love the questions themselves like locked rooms and like books written in a very foreign language. Do not search now for answers that cannot be given to you because you could not live them. And it is about living everything. Live the questions now. Perhaps you will then gradually, without realizing it, live into the answer one day in the distant future.
> Rainer Maria Rilke to Franz Xaver Kappus (1903)

Stopping time by refusing to eat or using puberty blockers

Maladaptive solution strategies for conflicts in female adolescence

What determines **which mode of conflict processing or which maladaptive behaviors** are activated in the event of deficient self-development or crisis-like decompensation during puberty? This is likely to depend on a large number of variables, pathogenic developmental conditions and the interaction of different psycho-social-familial constellations with individual and even biological dispositions – in the sense of a classic gene-environment interaction. As a result, the question cannot ultimately be answered satisfactorily. In the case of both anorexia nervosa and clinically relevant gender dysphoria, theory-based concepts lead to different, not necessarily contradictory, but complementary statements regarding possible causal conditions. In both cases, caution should be exercised when making generalized statements and attempting to provide a monocausal explanation.

Anorexia as an solution strategy – Escape from femininity and search for autonomy

Eating disorders in female adolescents and young women are a widespread phenomenon. Girls between the ages of 13 and 16 are significantly more likely than boys to exhibit restrained eating behavior (calorie restriction) with a simultaneous strong dissatisfaction with their bodies and **more intense experiences of body alienation** (body image disorder). The number of cases of anorexia treated as inpatients has risen over the past ten years and increased again during the coronavirus pandemic. (Kölch et al., 2023).

The development and maintenance of an eating disorder is seen as a multifactorial disease process in which individual psychological factors interact with biological (partly genetic), familial, and sociocultural factors. However, the exact details are unclear, especially regarding the interplay of various factors and their respective weight in individual cases (Korte & Wagner, 2020). In principle, the symptoms can be understood as an expression of an internal conflict. Eating can serve as a substitute satisfaction for unfulfilled needs; on the other hand, abstaining from eating conveys a feeling of control, independence, and strength. There are various psychodynamic explanatory models that refer to the individual's life history, particularly in early childhood ("structural disorder"), emphasize intrapsychic or interpersonal conflicts (e.g., autonomy versus dependence) or refer to **unresolved developmental tasks** (i.e., sexual maturation, growing up) or a profound insecurity of the self and, as a consequence, **rejection of femininity or the female gender role.**

Anorexia is a desperate attempt to stop time, to put the body, which is perceived as being out of control during puberty, in its place, to create order, at least in one's own body, when various other problems seem to lead to a dead end. The body becomes the venue for inner conflicts, and the great **the great discipline of dieting**, with a high degree of bizarre ritualization, replaces control over one's own life. In this way, paralyzing feelings of powerlessness can be transformed into feelings of power. Anorexia is often an expression of a search for the "lost paradise of childhood", however little paradisiacal this may have been in individual cases, but it is always a **search for boundaries, for autonomy, for identity**, for oneself. Anorexic girls are hungry not only in a concrete but also in a figurative sense. They are hungry for autonomy but fail at the pitfalls of growing up: accepting the female body with its expressions and attributions and forming sexual relationships under the given social norms (Gille et al., 2017). Ambitious-perfectionist girls in particular experience recognition within their peer group with their "body strategy" and are rewarded with feelings of stability, supposed independence and the **aura of the extraordinary**, supposedly special.

Much of what has been said applies equally to the genesis and typical psychodynamics of clinically relevant gender dysphoria. It is therefore not surprising that patients with gender identity conflict (in addition to an affective disorder) often also have comorbid eating disorder symptoms – with deviations in eating behavior in both directions, i.e., partial or complete anorexic or bulimic eating disorder syndromes as well as obesity (Diemer et al., 2015; Holt et al., 2016). It is quite obvious that the **body schema disorder** underlying the eating disorder is closely related to gender and sexual identity issues.

Exit strategy *trans* – Crossing borders and searching in the fictional-imaginary

The number of minors, primarily female adolescents, who present for treatment of a gender-related identity conflict has risen steadily in Western countries in recent years (Aitken et al, 2015; Chen et al, 2016, 2023; Kaltiala-Heino & Lindberg, 2019; Kaltiala-Heino et al, 2020; Thompson et al, 2022; Van der Loos et al, 2023).

In some countries, the **increase in patients with gender dysphoria** seeking transition in specialized counselling and treatment centers was up 4500% within a ten-year period (2009-2018) (de Graaf et al., 2018). As noted earlier, the **inversion of the sex ratio**, i.e., the reversal of the numerical ratio of affected girls to boys, requires explanation (de Graaf et al., 2018; Kaltiala-Heino, Bergman, Työläjärvi & Frisén, 2018; Zhang et al., 2021). According to a U.S. study, the number of mastectomies performed on girls aged 12 to 17 increased thirteenfold between 2013 and 2020 (Tang et al., 2022). At the same time, there is growing evidence that the clientele seeking treatment has changed in other respects – there has been a **significant increase in psychiatric comorbidity**, as has been documented several times (Herrmann et al., 2022; Kaltiala-Heino, Holttinen & Tuisku, 2023; Kaltiala-Heino, Sumia, Työläjärvi & Lindberg, 2015; Twist & de Graaf, 2019).

Similar to anorexia, pubescent girls are offered another, albeit particularly drastic opportunity to avoid dealing with maturity-related changes and developmental tasks and to express their individual suffering – in a form that is accepted in our *time* and *culture*. With regard to the overall group of affected female adolescents, it is by no means possible to assume a homogeneous patient collective with a uniform etiology, but rather a **different individual cause and condition structure**. During the diagnostic and therapeutic processes, a multitude of possible causes of gender dysphoria may emerge and to which an alleged (or actual) trans-identification may be attributed. The most common causes and **distinct manifestations** are:

- Gender dysphoria as an expression of a temporary *age-role conflict* or an adjustment disorder in the context of adolescence or sexual maturation crises (i.e., as a result of failure in pubertal developmental tasks);
- Persistent discomfort, acceptance difficulties or *permanent non-conformity with common gender role expectations, i.e.,* the requirements, rules and norms of how girls/boys should behave in the respective culture;
- Gender dysphoria as a result of repressed *ego-dystonic homosexuality* or in the context of sexual preference peculiarities (the latter plays a role as a motive almost exclusively in biologically male adolescents);
- Gender dysphoria *in other severe mental illnesses, e.g.,* autism spectrum disorder, or as a trauma-compensatory reaction pattern or as part of an overarching identity diffusion in personality disorder.

There are a number of important similarities between gender dysphoria and anorexia: In the absence of real and constructive-functional solution strategies, psychological conflicts are projected onto the body, transferred to the somatic level, so to speak. Due to the lack of self-acceptance or the pronounced self-hatred in connection with a massive body image disorder, **aggression is turned against one's own self**, inward, but also outward, against important others. In both anorexic eating disorders and gender identity disorders (gender dysphoria), relatives, especially parents, are exposed to strong feelings of helplessness and powerlessness in addition to the massive feelings of guilt and failure that often arise. In both disorders, this sometimes exacerbates the symptoms of the index patient within a correspondingly pathological relationship dynamic.

However, the trendy diagnosis of gender dysphoria or self-identification as *trans* offers two decisive advantages over anorexia and bulimia nervosa: first, in comparison to eating disorders, the projection surface for gender incongruence is more diverse, and the boundaries are not only sought, but crossed in a very concrete, not just symbolic way. Secondly, gender incongruence and "being trans" are currently extremely socially and politically legitimized and have been defined as a matter of human rights in recent years, which is also reflected in the planned "law of self-determination". As a result, those affected experience strong **external validation and positive reinforcement** in their disorder – which, according to the proponents of a transaffirmative care, should no longer be described as such.

Trans as a zeitgeist phenomenon – The healthcare system as part of the problem

Anorexia and bulimia nervosa are often described as **modern ethnic disorders**; this certainly applies even more to the current hype surrounding the phenomenon of gender incongruence, "trans" and "non-binary", which is particularly widespread among youth in Western industrialized countries. The dynamic interactions of zeitgeist and role perception and the important significance of cultural influencing factors, in particular reinforcement through social networks and Internet forums are well known for both conditions or maladaptive conflict processing modes. They have been described just as conclusively as the fatal effect of social contagion, which can also occur via media exchange processes, i.e. purely virtual encounters with like-minded people or similarly vulnerable peers (Littman, 2018). In the case of psychogenic eating disorders, this has repeatedly prompted initiatives to ban such forums and websites, which glorify anorexia as a way of life and aggressively promote starvation diets. However, all attempts to block 'pro-ana' websites, have been only partially successful despite their potential to harm young people.

The **significance of cultural upheavals and civilizational crises** to the rise of the zeitgeist phenomenon, "Transgenderism" in the postmodern era cannot be overlooked. Our thesis that this could be **a crisis solution that has been shifted to the individual** has been discussed in detail (Korte & Tschuschke, 2023). In addition, it should be noted that there is a very conspicuous, sometimes voyeuristic fascination in our society for self-harming behaviors, especially among young women who submit to trends. Examples of this would be the cult surrounding the 1960s anorexic model *Twiggy,* who became a style icon of her time and contributed significantly to the popularization of anorexia; as well as the broad interest of a shocked public in the fate of the heroin-addicted 13-year-old *Christiane F.*, the collective "lust for fear" in the face of the prostitution and drug deaths of *The Children from Bahnhof Zoo*, after the publiccation of the book of the same name in 1978, which sold more than three million copies worldwide and was also made into a movie.

It is also impossible to overlook the **susceptibility of medicine and psychology to the phenomenon of (media-triggered) mass hysteria.** This can occur when enthusiasm for new phenomena leads to new and misleading diagnoses that find their way into medical classification systems and "stand up" to appropriate scientific scrutiny for decades without being questionned or corrected. Once the symptom patterns are codified and validated, they can be found by those who are unconsciously looking for a way to express their otherwise difficult-to-verbalize distress (Marchiano, 2021). There is a clear parallel here between the so-called *multiple personality disorder* of the 1990s and the trans diagnoses that have become so common among young people today, or rather their early affirmation by the medical establishment, activists, and the media. Both – as well *as self-harming behavior* and "classic" *hysteria* – preferentially affect young women, who have always proven to be particularly susceptible to social contagion phenomena (Papadima, 2019).

Self-empowerment instead of gender-trouble

Treatment of gender dysphoria and starting points for prevention

In contrast to anorexia treatment, for which an eclectic therapeutic approach – combining cognitive behavioural measures with conflict-centred/revealing or psychodynamic and systemic-family therapeutic methods – is available and has proven effective, the optimal approach for treating gender dysphoria has not yet been determined. However, the **priority of psychotherapeutic treatment** for eating disorders has never been questioned. The debate about the optimal care of gender dysphoric, trans-identified and, more recently, "non-binary" minors has the capacity to divide clinicians – the child and adolescent psychiatric and psychotherapeutic community – like no other issue.

Controversy surrounding various treatment strategies for gender dysphoria

There are widely divergent views in the literature regarding the basic therapeutic approach to the treatment of gender dysphoric youth; there are also fundamentally different opinions about the importance and earliest possible time for the initiation of body-altering measures. Essentially, two opposing positions and disparate clinical-therapeutic approaches can be distinguished:

a) **Transaffirmative therapy** does not question the desire to transition and more or less automatically presents puberty-blocking treatment as medically safe and ethically unproblematic (Chen et al, 2023; Coleman et al, 2022; de Vries et al, 2011; Hembree, 2011; Romer & Lempp, 2022; Romer & Möller-Kallista, 2020, 2021). Proponents of this approach usually assume a neurobiological-genetic determination of

gender identity (which is not tenable given the scientific data available).

A therapeutic-pedagogical attitude that uncritically reinforces the child or the adolescent in his or her supposed "trans-identity" lacks basic knowledge of developmental psychology and adolescent crises. The early onset of this course predisposes persistence of gender dysphoric symptoms and progression to medical and surgical treatment that is fraught with risks and side effects.

b) The **gender-critical or gender-exploratory approach,** aims to initiate a process of reflection in order to explore the different motives for transidentification, to treat the accompanying psycho-socio-emotional problems and comorbidities, to minimize the risk of persistence of gender dysphoria and to identify alternatives to medical transition. Essentially, the aim is to critically question gender stereotypes and unrealistic expectations about 'gender transition', to promote agency and autonomy and to enable those affected to develop creative solutions for their identity conflicts (Ayad et al., 2022; D'Angelo, 2023; D'Angelo et al., 2021; Korte, 2022). This includes clarifying whether a request for transition is an attempt to solve a completely different problem (Korte et al., 2014, 2017).

The professional debate about the pros and cons of setting the medical course early is dominated by the highly controversial question of whether and to what extent **halting pubertal development** with GnRH analogs is a medically *safe*, *suitable,* and *ethically justifiable* therapy for the goal of reducing suffering (Abbruzzese, Levine, Mason, 2023; Bell, 2023; Biggs, 2020; D'Angelo et al, 2021; Korte & Siegel, 2024; Korte et al, 2021). Complex meta-analyses that included 1,132 youth with gender dysphoria from 16 observational studies (no controlled comparative studies were included and six of the 16 studies analyzed were funded by the pharmaceutical industry) criticized the **lack of evidence for the benefits** of early hormonal treatment (i.e., puberty suppression and opposite-sex hormones) (Chew et al., 2018; Mahfouda et al., 2019). At the same time, there is mounting evidence of potential risks, side effects, and unfavorable long-term consequences of GnRH analogues. A full discussion of the risks, benefits, and as yet unknown harms is beyond the scope of this article (see Lenzen-Schulte, 2022a/b; Korte & Siegel, 2024).

In view of these findings, several countries have retreated from a transaffirmative approach and now strictly limit the use of puberty blockers in gender dysphoric children, only allowing them in the context of scientifically controlled studies or no longer allow them at all (England, Finland, Sweden, Denmark, Norway, France, several states in the USA). This is also due to the fact that an increasing number of those treated regret their decision in the course of their further development and have suffered as a result of medical interventions (Boyd et al., 2022; Hall et al., 2021; Littman, 2021; Littman et al., 2023; Roberts et al., 2022; Vandenbussche, 2022) Furthermore, some young patients claim that their feelings at the time were taken for granted and never really questioned, which is why they made hasty rather than thoughtful, considered decisions. In some cases, unhappy patients litigate against their former clinicians and practitioners.

Recommendations for practice – Preliminary conclusions

If people of any age feel psychological suffering due to their physical gender and want to seek help, doctors should take their suffering as well as their life plans seriously and not pathologize the latter as such. However, they should also be wary and question any universal idea of salvation that seeks to alleviate psychological suffering primarily through the implementation of aesthetic-surgical measures. Above all, it is important to recognize the variety of possible causes for gender dysphoria and gender incongruence of pubescent girls and **not to hastily collude in their use of the trans-identification template**. In the vast majority of cases of gender dysphoria in adolescence, it is a matter of an **age-role conflict or a temporary insecurity** of *sexual*, rather than *gender* identity. This applies in particular to gender-related identity conflicts or trans-identifications that arise during puberty (ROGD) and can be classified as a maladaptive coping strategy for problems typical for this age and developmental stage.

It is also important to recognize the existence of a small, difficult to quantify subgroup with indications of a **persistent gender identity problem.** If, after careful exploration of the previous life history, it appears that there is more behind the experience of gender incongruence than a psychological crisis and adjustment disorder, a referral should be made to a specialized institution, or it should be consulted for advice. In view of the fact that for some of the girls, sexual traumatization, experience of violence or repressed ego-dystonic homosexuality (Drummond et al., 2008, 2017; Singh, 2012; Steensma, McGuire et al., 2013; Steensma, van der Ende et al., 2013) may be possible motives for trans-identification fantasies or the desire for a "sex change".

Distinguishing the motivation for gender transition requires a **high degree of professional expertise**, which ideally extends to special *sex therapy* knowledge in addition to general *developmental psychiatric* knowledge. The aim of **minimizing the number of requests to detransition** by

differentiating within the heterogeneous trans spectrum should not be dismissed as paternalism and interference in the patient's personal concerns but should be understood as an expression of the doctor's duty of care. Hormonal treatment and/or surgical interventions on a healthy body may only be promising to some extent in the very rare cases of longstanding, persistent gender dysphoria.

In view of the astonishingly anti-psychotherapy orientation and non-evidence-based **fixation on body-altering treatments on part of the trans-affirmative approach**, in which a loss of fertility and further long-term physical damage are accepted with the initiation of a medical transition, the rationale for attempting to solve a *psychological* problem using *somatic* measures should at least be mentioned in passing and presented as worthy of discussion: In the case of the clinical presentation of anorexia nervosa, which is similarly based on a body perception disorder and often also a rejection of sexuality, no one would consider prescribing laxatives, appetite suppressants, diuretics or thyroid hormones to the anorexic patient in order to enable her to achieve the desired body modification – in this case further self-induced weight loss.

There is an urgent need to return to a **non-essentialist understanding of identity** in the care of gender dysphoric minors and to return to **basic knowledge of developmental psychology.** Furthermore, it makes sense to make more intensive use of the experience gained with severe body image disorders in the context of anorexia treatment and to use this *mutatis mutandis* in therapy for massive rejection of the sexual body, as suggested by Ponseti & Stirn (2019). Complete social (Morandini et al., 2023), legal (Korte, 2021; Korte & Siegel, 2024)[3] and medical gender transition should only be considered after the completion of psychosexual development, the identity-forming experiences of which form the basis of adulthood. Identity formation is the result of successful development during puberty, not its starting point.

Preventive approaches in the context of basic psychosomatic care

What can pediatricians, child and adolescent psychiatrists, family doctors, general practitioners and gynecologists do to provide the best possible support for the physical and psychosexual development of adolescents and to promote their mental health during puberty? How can they help adolescent girls in particular to solve **age-specific problems**, which occur more frequently and primarily in early to mid-adolescence as part of primary medical care?

Negative (depressive) self-concept, body dysphoria and the feeling that boys have it easier are – as we know and have explained with reference to gender-typical differences in the experience of physical maturation processes – quite common in girls while dealing with pubertal developmental tasks. Coping with these is a huge challenge *a priori*, which is why **temporary crises** in this phase should not be pathologized *per se* and unnecessarily. Psychosexual development is particularly susceptible to disruption in girls who have few resources due to their family situation or a difficult life history (Becerra-Culqui et al., 2018; Kaltiala-Heino et al., 2015; Kozlowska et al., 2020). Whether development during puberty leads to personal fulfillment and a stable female identity or results in psychiatric/psychosomatic illnesses depends not least on the quality of support girls receive when they are at risk of losing their sense of coherence with their own bodies during puberty.

> "It depends [...] very much on how a young girl gets to know and understand her body. Whether one's own body is experienced as rather deficient or as complete, as repulsive or as lovable, as weak or as potent, is fundamental to the path a girl takes in the transition to adult womanhood and the position she takes in gender relations and in society" (Waldeck, 2003).

In general, girls in the transitional phase of puberty are very open to **support and information** that helps them explain, understand, and anticipate the changes, impressions and sensations that are assailing them from inside and outside. There is no doubt that efficient prevention today requires more than ever a **ideology-free, face-to-face discussion** with a competent professional, with which girls can develop body acceptance and well-defined sexual self-confidence. Femininity exists in the body, not as far away from it as possible. In order to be able to appreciate and protect their changing bodies, girls need information about:

- female anatomy and the changes they notice in themselves as they mature,
- the great variability in normal physical development and the reasons for girls' lack of body acceptance,
- the fascinating cyclical processes in girls' bodies, fertility and the physical signals that girls notice about themselves in this context,
- menstruation, menstrual problems and menstrual hygiene,
- the sex-specific characteristics of female sexuality and its functional dimensions, which vary in importance depending on age and developmental phase,
- how to access safe contraception and safe protection against sexually transmitted diseases.

3 See the detailed expert opinion on the so-called "Self-determination law" at https://sexuologie- info.de/artikel/2023.34.31.pdf

Furthermore, girls must not feel alone and isolated in their perception of the painful discrepancy between the theoretical idea of gender equality and the harsh reality of sexual objectification (Nadrowski, 2023).

Most female patients have probably already taken part in sex education lessons at school several times. However, teachers have to modify their information and advice when teaching boys and girls together, in order to account for respective feelings of embarrassment, shame, and unease. Individual questions and problems are generally not discussed. "I have a question..."– Girls rarely make it that easy. This is because formulating their own questions requires experience that the girls do not yet have. They may be navigating a disturbing reality, but it doesn't necessarily lead to specific questions.

Doctors must therefore approach girls on their own initiative and initially pose questions that do not overwhelm them. Girls like to respond to questions that frame the topic from the outside. Depending on their age and comprehension skills, the clinician can then be more specific: "You're clearly going through puberty yourself, do you feel that everything is quite normal?" or "Is there anything that worries you?" or "How are you doing with your period?" "Is there something you can't explain?" But what if the girl doesn't respond to **questions with a clear prompting character**? This scenario will likely remain the exception, but in this case it should be addressed in a reassuring way: "If you don't have any specific questions now, then that's not abnormal either." This way the girls will definitely feel heard, respected, accepted and reassured. Of course, clinicians can raise a topic on their own initiative: "While you're here, I'd like to explain something to you because I know that many girls are unsure whether... / have a problem with the fact that ...." The young person should be given the feeling that she can come in at any time she has an urgent question or a problem.

If, after the first contact, the girl at best thinks: "But she/he was nice", then this positive experience is already an **important first step towards prevention,** for which the girl who was perhaps initially unable to express her curiosity or relief due to insecurity and embarassment will also be grateful (Gille, 2021). **Ideally, empathetic and non-judgmental, exploratory questions** about sexuality, one's own gender role and gender identity should be part of the permanent repertoire of all doctors dealing with adolescent patients. It is an extremely rewarding task for doctors to offer opportunities for conversations to help girls develop accepting and appreciative, positive relationships with their maturing bodies, their femininity and their sexual identity.

Only in this way is it possible, in view of the vast number of counseling services and influencers on social media – from well-intentioned to subversive, from ineffective to soul- and life-destroying, from politically motivated to experimenting with the well-being of children and adolescents far beyond the Hippocratic oath – to provide empathetic, factual, competent, and responsible medical assistance.

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