Acta Paediatrica

WILEY

READER'S FORUM OPEN ACCESS

Concerns Regarding Data Modelling and Interpretation in Ruuska et al.

E. Kale Edmiston[1] | Jennifer Urbano Blackford[2] | Jay C. Fournier[3] | Stephanie Budge[4] | Christa Ventresca[5] | Krisha Aghi[6] | Troy A. Roepke[7] | Sarah Victor[8]

[1]Department of Psychiatry and Behavioral Sciences, UMass Chan Medical School, Worcester, Massachusetts, USA | [2]Department of Neurological Sciences and Pediatrics, University of Nebraska Medical Center, Omaha, Nebraska, USA | [3]Department of Psychiatry and Behavioral Health, The Ohio State University Wexner Medical Center, Columbus, Ohio, USA | [4]Department of Counseling Psychology, University of Wisconsin-Madison, Madison, Wisconsin, USA | [5]Department of Genetics and Genomics, University of Michigan, Ann Arbor, Michigan, USA | [6]Department of Integrative Biology and Physiology, University of California Los Angeles, Los Angeles, California, USA | [7]Department of Animal Sciences, Rutgers University, New Brunswick, New Jersey, USA | [8]Department of Psychological Sciences, Texas Tech University, Lubbock, Texas, USA

Correspondence: E. Kale Edmiston (kale.edmiston@umassmed.edu)

Received: 28 April 2026 | **Revised:** 28 April 2026 | **Accepted:** 22 May 2026

We disagree with Ruuska et al.'s interpretation of data purporting that youth referred for gender-affirming healthcare (GAH) show persistent psychiatric morbidity, and suggesting that GAH '...might even have a negative impact' [1]. This interpretation is particularly remarkable given the authors did not engage with the established literature showing quite the opposite [2].

The study refers to 'need', but measures utilization. Because psychiatric assessment is required to access GAH, and prior contact predicts future contact, transgender people may be more likely to continue services than cisgender people with similar needs. While the authors exclude utilization within 2 years of GAH, this remains a confound. Despite reporting utilization frequency (Table 1), the analyses reduce data to a binary variable. This is inconsistent with the authors' conclusion that transgender patients have '...long-standing psychiatric morbidity and/or particularly severe symptoms', as they did not measure symptom severity/duration.

The manuscript suffers from a lack of preregistration; models appear to be largely *post hoc*. For example, the authors argue for a cohort effect by dividing the sample by GAH initiation pre/post 2011, with little justification. More plausible than a difference between GAH-seeking youth pre/post 2011, the WPATH Standards of Care 7 removed the requirement that mental health concerns be 'reasonably well-controlled' prior to accessing GAH in 2011 [3]. Before this change, many transgender people minimised mental health concerns or avoided psychiatric services to access GAH [4]. Indeed, the earlier cohort shows a utilisation pattern post-index date akin to the later cohort. Lower service usage before GAH access pre-2011 likely reflects changes in access, not disparities in need.

Although the authors describe increased treatment utilization following GAH as 'considerable' versus 'minor' for youth who did not access GAH, they did not compare youth who accessed GAH with those who did not, instead comparing both groups to controls. However, post-index date service usage is comparable for both groups seeking GAH. These results were not interpreted; instead the authors note there is a larger *increase* in psychiatric utilization pre/post-index date in those who received GAH. This is almost assuredly an artefact of the mechanisms through which GAH is accessed in Finland. There are group differences in treatment utilization *prior* to accessing GAH, which is consistent with reports that the Finnish system uses nonstandard screening, with > 50% turned away. It is likely that the increase in utilization is not due to increased need, but reduced service utilization before index date predicting who can access GAH.

Psychiatric service utilization is not itself a concerning outcome. It is likely that treatment engagement reflects efforts to cope with marginalization and minority stressors, which may increase following GAH. The limited analyses presented here cannot be used to draw conclusions about mental health after GAH, nor can they be used to compare those who accessed GAH

and those who did not. Based on the misrepresentation of data, misinterpretation of findings, and inappropriate controls, we request a reanalysis of the data using frequency of treatment and within-person modelling, followed by re-review.

Author Contributions

E. Kale Edmiston: conceptualization, writing – original draft, writing – review and editing. **Jennifer Urbano Blackford:** conceptualization, writing – review and editing. **Jay C. Fournier:** conceptualization, writing – review and editing. **Stephanie Budge:** conceptualization, writing – review and editing. **Christa Ventresca:** conceptualization, writing – review and editing. **Krisha Aghi:** conceptualization, writing – review and editing. **Troy A. Roepke:** conceptualization, writing – review and editing. **Sarah Victor:** conceptualization, writing – review and editing.

Conflicts of Interest

Dr. Edmiston has served as a paid consultant for Lambda Legal to provide expert testimony in court cases. Dr. Budge has been hired by the ACLU, Lambda Legal, the National Center for Lesbian Rights, Gender Justice, Public Justice, and Wardenski P.C. to provide expert testimony in court cases. Dr. Fournier receives royalties from Guilford Press. The other authors declare no conflicts of interest.

Data Availability Statement

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

References

1. S. M. Ruuska, K. Tuisku, T. Holttinen, and R. Kaltiala, "Psychiatric Morbidity Among Adolescents and Young Adults Who Contacted Specialised Gender Identity Services in Finland in 1996–2019: A Register Study," *Acta Paediatrica* (2026), https://doi.org/10.1111/apa.70533.

2. T. A. Croteau, J. Gelech, M. A. Morrison, and T. G. Morrison, "Psychological and Physical Health Outcomes Associated With Gender-Affirming Medical Care for Transgender and Gender-Diverse Youth: A Critical Review," *Healthcare (Basel)* 13, no. 14 (2025): 1659, https://doi.org/10.3390/healthcare13141659.

3. E. Coleman, W. Bockting, M. Botzer, et al., "Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7," *International Journal of Transgenderism* 13, no. 4 (2012): 165–232, https://doi.org/10.1080/15532739.2011.700873.

4. K. R. MacKinnon, D. Grace, S. L. Ng, S. R. Sicchia, and L. E. Ross, ""I Don't Think They Thought I Was Ready": How Pre-Transition Assessments Create Care Inequities for Trans People With Complex Mental Health in Canada," *International Journal of Mental Health* 49, no. 1 (2020): 56–80, https://doi.org/10.1080/00207411.2019.1711328.