



# City of Bloomington Common Council

## Legislative Packet – Addendum

Posted on Tuesday, 11 June 2024

Wednesday, 12 June 2024

Regular Session at 6:30 pm

To: City Council Members

From: Special Committee on Council Processes

Isabel Piedmont-Smith, Chair

Isak Asare

Matt Flaherty

Dave Rollo

Date: June 12, 2024

Subj: Proposal to replace some Regular Sessions with Consensus-Building Activities on the Council calendar for the remainder of 2024

This spring, the Special Committee on Council Processes has considered alternative meeting structures for the City Council in order to improve processes and outcomes for engaging Bloomington residents. Our starting point was to recognize the following challenges with only holding regular session meetings guided by Roberts Rules of Order:

1. Lengthy and rigid procedures often stifle open dialogue and creativity.
2. An emphasis on formalities can alienate members of the public, council members, and staff, deterring meaningful participation.
3. Strict adherence to parliamentary rules may prioritize process over substance, hindering the exploration of innovative solutions. This also favors those who master the process and not necessarily those with the best ideas.
4. Our processes create a tendency towards adversarial dynamics, undermining the spirit of cooperation and compromise.
5. The Council as a body does not have enough time on a week-to-week basis to collectively engage with the issues facing our community, and some of the time during our regular sessions is taken up by formalities.

Overall, the committee members concluded that there is a lack of meaningful collaboration with the public, city staff, and each other *prior* to making decisions in the formal setting of Council regular sessions.

As a partial solution to these problems, Council Member Asare proposed that we reduce the number of regular sessions and add into our schedule Consensus-Building Activities (CBAs). CBAs encourage active listening, brainstorming, and the exploration of shared interests to reach mutually beneficial outcomes. By fostering a culture of trust and cooperation, a CBA cultivates a more inclusive decision-making process and promotes buy-in from all stakeholders. The goal is not necessarily to arrive at a unanimous decision but to find a solution that everyone can support or at least live with, i.e. a solution that no one feels the need to vote “no” on.

Some key aspects of consensus building include:

- **Active Listening:** Ensuring that all participants feel heard and understood, which can help in identifying common ground.
- **Open Dialogue:** Encouraging open and honest discussion about different viewpoints to understand the interests behind positions.
- **Inclusive Participation:** Making sure all stakeholders or affected parties have a chance to contribute to the discussion, especially emphasizing outreach to those who are or may be harmed by a current system or potential policy change.
- **Problem Solving and Deliberation:** Focusing on finding solutions that address the concerns of all parties and finding common ground rather than winning an argument.
- **Flexibility:** Being open to changing one's position in light of new information or understanding others' perspectives better. Being flexible with approaches and rules so as to allow all of the above.

In our last committee meeting, we discussed the following scenarios in which a CBA could be useful, listed below in order of more general to more specific.

1. Discussion of a community problem and possible solutions (legislative or otherwise)
2. Development of legislation or policy regarding an issue
3. Discussion of legislation that is ready for introduction, but not yet introduced for First Reading
4. Discussion of legislation that has been introduced via First Reading, but the Council wants to have an open discussion before Second Reading

The CBA would be structured differently depending on the situation. Agenda items for a CBA could come from the Council President or any three Council Members, and the agenda could also be discussed during the Council Schedule portion of a regular session meeting.

The committee would like to “test drive” the CBA format by revising the Council schedule for the year (after the summer recess) by canceling three regular sessions and inserting three CBA sessions instead. We envisioned one CBA per month, on the third Wednesday of the month, and thus limiting regular sessions to the first two Wednesdays of the month. However, since October already has a special session scheduled for budget legislation, and December only has two regular sessions scheduled, we have decided to propose just three CBA sessions. We propose to change the following regular session meetings to CBA sessions:

Wednesday, August 14

Wednesday, September 11

Wednesday, November 13

We have conferred with Clerk Bolden, who is willing to provide memoranda of the CBA meetings but not minutes. In lieu of minutes, a transcript can be generated and the meeting recorded using OtterAI, an AI software program that the Clerk’s Office already has. Council Member Piedmont-Smith also talked with Mayor Thomson about the CBA proposal, and she indicated a willingness to collaborate with the Council in that setting. The format of the CBA sessions will be developed by the Council President in consultation with other interested Council Members and Council staff.

We respectfully request that the Council approve the change in schedule proposed here.

**Council Member Asare’s list of some suggested readings about CBAs:**

Susskind, L., & Cruikshank, J. L. (2006). *Breaking Robert's Rules: The New Way to Run Your Meeting, Build Consensus, and Get Results*. New York, NY: Oxford University Press.

Susskind, L., McKernan, S., & Thomas-Larmer, J. (Eds.). (1999). *The Consensus Building Handbook: A Comprehensive Guide to Reaching Agreement*. Thousand Oaks, CA: Sage Publications.

Fisher, R., Ury, W., & Patton, B. (2011). *Getting to Yes: Negotiating Agreement Without Giving In*. New York, NY: Penguin Books.

Innes, J. E., & Booher, D. E. (2010). *Planning with Complexity: An Introduction to Collaborative Rationality for Public Policy*. London: Routledge.



Memo from Rollo/Ruff on Resolution 2024-14.

As strong supporters of the LGBTQ+ community and equal rights for all, we took it very seriously when we recently became aware of significant high-profile controversy involving the organization WPATH (World Professional Association for Transgender Health), and also that the governments of several European nations had recently enacted restrictive and prohibitive positions and policies towards certain kinds of gender-affirming care for minors.

Recognizing how extremely important the implications of these issues are, especially as they pertain to minors, and how thoroughly complex the issues are, with the highest level of due diligence being demanded in taking up a City resolution on gender-affirming care that includes minors and promotes the use of such methods as puberty blockers and surgeries, we requested that the sponsors of the resolution take Resolution 2024-14 off of a fast-track to allow time to investigate. The sponsors of this resolution would not agree to take more time. This memo and packet addendum is the alternative we were left with to explain our concerns and provide information and reference materials that illustrate why we would be reluctant at this point to vote yes or no on this resolution. Quite simply, more time is required to get a better understanding of the controversies, associated policy changes, and the most current scientific information regarding minors and certain types of gender-affirming care.

The resolution draft was reviewed by City Legal and their approved version was made available to Council members just three days before it appeared in the packet. This fast-tracking has placed us in the nearly impossible position of adequately processing conflicting and contradictory evidence about gender-affirming care (also known as gender transitioning), which involves puberty blockers (in the case of children and adolescents), cross-sex hormones, and surgeries.

This is a very sensitive topic, that should be discussed with care, dignity and respect for those who choose to transition, and empathy for what are significant difficulties that may be encountered in the process. We also unequivocally condemn discrimination directed to trans individuals and note our long support of the LGBTQ community.

Sadly, politicization of the topic of gender-affirming care is rampant, especially in the U.S., with each side of the spectrum wishing to score points. This has created an environment where asking questions and examining data is denounced and the questioner maligned. This is a terrible situation for medical science to operate in. Debate and discussion are essential for understanding any topic of inquiry, especially one that is so consequential and where experts clearly disagree.

We fully support the bodily autonomy of adults and their right to undergo hormonal treatment and surgeries – with informed consent – the foundation of medical ethics. But children are a different matter for several reasons. First, minors cannot legally provide informed consent; their parents or legal guardians must grant consent. Furthermore, with respect to gender-affirming care, children generally lack the cognitive development to understand the implications of

sterility, inability to experience orgasm, and other potential but serious complications of gender transitioning. Third, because children have not gone through puberty, gender-affirming care involves even more life altering and irreversible changes to their person than is the case for adults who undertake such care.

Parents or legal guardians of children are responsible for their children's well-being, and for protecting them from abuse or hazard. In the case of medical interventions, parents must be properly and fully informed of the risks and hazards and so must children, to the extent that children can understand them. However, we find there is substantial debate on the risks and hazards of the chemical, hormonal, and surgical treatments involved in gender transitioning for children and whether children are provided opportunity to assent to such procedures.

This debate has focused on data – particularly its quality and the absence of long-term studies. It has also focused on ethics, both for reasons already mentioned and in light of recent leaks of internal discussions of a leading gender transitioning advocacy group – WPATH (World Professional Association for Transgender Health). As investigations reporter Jennifer Block explains in her *British Journal of Medicine* article of February 23, 2023 titled “Gender dysphoria in young people is rising—and so is professional disagreement”:<sup>1</sup> “*Three organizations (sic) have had a major role in shaping the US’s approach to gender dysphoria care: WPATH, the AAP, and the Endocrine Society.*” These organizations inform other professional medical organizations on the topic and all three of them are referred to in Resolution 2024-14.

Block goes on to describe the data deficiencies coming from each of these organizations as reviewed by medical experts, and the need for greater stringency in research methods.

In England, whistleblowers at Tavistock (England’s National Health Services (NHS) only gender clinic for children) called attention to what they asserted were unsafe conditions, and to what the staff whistleblowers called an “*unquestioning affirmative approach.*”<sup>2</sup> In response, an independent review was conducted, resulting in the “Cass Report”<sup>3</sup> that resulted in the clinic’s closure. The Cass Report reveals that children were coached by Tavistock staff about what to say to receive puberty blockers.<sup>4</sup> Subsequently, the NHS has restricted gender transitioning for individuals under the age of 16.<sup>5</sup> Similar restrictions have now been implemented in other European countries, such as Norway, Sweden and Finland.<sup>6</sup>

Resolution 2024-14 states that gender transitioning for children and adolescents is associated with better mental health outcomes and lower rates of suicide. Studies have called these claims into question with closer analysis of the quality of the data. Small sample size, biased sampling, and failure to follow up on patients render this research of poor quality.<sup>7</sup>

Last year, the Endocrine Society’s new president Stephen Hammes asserted a linkage between gender transitioning and alleviating suicide. The organization and Dr. Hammes have since been taken to task in a July 23, 2023 editorial in the *Wall Street Journal* titled: “The Endocrine

Society's Dangerous Transgender Politicization,"<sup>8</sup> which was signed by 21 experts in the field of pediatric gender medicine from 8 countries.

The letter states that health authorities abroad depend on systematic reviews of evidence to determine the efficacy of hormone treatment and have found the claimed benefits reflected in U.S. medical associations to be without dependable evidence. As journalist Leo Sapir reports *"among the international experts is Dr. Riita Kaltiala, chief psychiatrist at Tampere University gender clinic, author of numerous peer-reviewed articles on trans medicine, and Finland's top authority on pediatric gender care."*<sup>9</sup>

Sapir summarizes:

*"Dr. Hammes' claim that "gender-affirming care" is a suicide prevention measure, the intl' experts say in their WSJ letter, "is contradicted by every systematic review." Dr. Kaltiala had previously called the affirm-or-suicide narrative "purposeful disinformation" and its promotion (given the contagious nature of suicide) "irresponsible.""*

Sapir goes on to explain that the differences in the conclusions of U.S. medical associations versus international experts stems from the former's use of poor grade evidence rather than systematic reviews of evidence – the highest level of evidence-based medicine (EBM, see figure below). Sapir notes that systematic reviews of evidence *"furnish the highest quality evidence. They follow a rigorously developed, reproducible methodology. They do not cherry-pick studies with convenient results, but instead consider all the available research."*<sup>10</sup>

Because Resolution 2024-14 includes the position of the American Academy of Pediatrics, it is informative to note that, according to Sapir:

*"The American Academy of Pediatrics' main statement on gender medicine, authored by a single doctor while still in his residency, is not a systematic review. The author himself has conceded as much. A later published peer-reviewed fact check found the AAP statement to be a textbook example of cherry-picking and mischaracterization of evidence."*<sup>11</sup>

Beyond the quality of evidence debate, astounding revelations of medical ethics transgressions emerged in March of 2024 in the form of the WPATH Files.<sup>12</sup> WPATH is the World Professional Association of Transgendered Health and is featured in Resolution 2024-14 as an organization supporting that *"gender-affirming healthcare has been proven to be evidence-based, medically necessary, and lifesaving."* WPATH is also cited by many other health organizations as they are perceived to be experts in the field of transgender health.

The WPATH files were leaked by whistleblower(s) and consist of internal conversations, in both written form and on video.

According to the press release of the group Environmental Progress, who received the tranche:

*“Newly leaked files from within the leading global transgender healthcare body have revealed that the clinicians who shape how “gender medicine” is regulated and practiced around the world consistently violate medical ethics and informed consent.”*

Within the files (included in this Packet Addendum), doctors and clinicians at WPATH:

- Acknowledge to each other privately that children under their care cannot fathom the implications of their decisions (in violation of WPATH’s own Standards of Care 8 (SOC8)).
- Describe that parents may also not understand these implications.
- Make clear during a WPATH panel discussion (video is provided), that children are confused about outcomes of hormone therapy.
- Admit that children do not have the cognitive maturity to grasp the implications of sterility.
- Refer to follow ups that indicate 27% of those who transitioned (in a study with only 49% participation in the follow up) regret sacrificing their fertility.
- Discuss that a 9-year-old doesn’t have “the brain space” to understand lifelong sterility, but advocate for transitioning despite being “stumped” by incongruity of the practice and the child’s understanding.
- Admit that consent forms are not always read or understood, in contradiction to the SOC8 statement that careful evaluation is provided for each patient.
- Discuss patients with severe mental health disorders (multiple personality, schizophrenia and bi-polar) being allowed to transition, despite concerns about their ability to follow post-surgical instructions and procedures.
- Speculate about serious side effects of the treatments, including liver tumors.

There are many more examples that call into question a variety of medical/ethical practices, and which should clearly be investigated.

We include the WPATH Files with a report by Mia Hughes, a reporter with Environmental Progress who offers a description and review of the contents of the leaked documents. Ms. Hughes’ report is informative and provides context within the field of gender transitioning. Regardless of whether one agrees with Hughes’ report, one can view the WPATH files themselves to verify the above bullet points.

A further concern for us is the developing body of research that indicates that many children that exhibit gender dysphoria may simply develop to be same-sex attracted adults. The Cass Report Commissioned by the NHS indicates that this may be true for 89% of girls and 81% of boys. There is concern that guiding such children into transitioning may consist of a kind of gay conversion therapy<sup>13</sup> –in effect heterosexualizing gay children.

To conclude, while we fully support transgender people and acknowledge that they can lead happy and fulfilling lives, there is evidence that for minors, gender-affirming care involving

puberty blockers, hormone therapy, and surgery may be doing more harm than good. We, as council members, are not in a position to determine this at this time, but what we have described above gives us great trepidation about supporting gender transitioning in minors as is the aim of Resolution 2024-14.

We believe that investigations of WPATH and their practices should be conducted. And it should be determined to what extent WPATH has influenced other medical organizations. Furthermore, we hope that subsequent research, discussion, and debate happens in an open and transparent setting, and with the highest standards of scientific rigor including highly controlled, double-blind studies, peer review and systematic reviews.

We will be abstaining on support for Resolution 2024-14 until more clarity is achieved on gender-affirming care for minors. One of our council colleagues has described the resolution as “symbolic” as it beyond our home rule authority and we agree with his assessment. It is a serious matter, however, to support a policy that may be harming, not helping children.

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<sup>1</sup><https://www.bmj.com/content/380/bmj.p382>

<sup>2</sup><https://www.bbc.com/news/health-51806962>

<sup>3</sup><https://cass.independent-review.uk/home/publications/final-report/>

<sup>4</sup><https://www.dailymail.co.uk/health/article-13293513/Children-coached-NHS-doctors-puberty-blockers.html>

<sup>5</sup><https://www.usnews.com/news/health-news/articles/2024-03-20/england-is-limiting-gender-transitions-for-youths-us-legislators-are-watching>

<sup>6</sup><https://www.forbes.com/sites/joshuacohen/2023/06/06/increasing-number-of-european-nations-adopt-a-more-cautious-approach-to-gender-affirming-care-among-minors/>

<sup>7</sup><https://www.transgendertrend.com/the-suicide-myth/>

<sup>8</sup>[https://www.wsj.com/articles/the-endocrine-societys-dangerous-politicization-endocrinologists-gender-affirming-care-arkansas-dac768bd?mod=article\\_inline](https://www.wsj.com/articles/the-endocrine-societys-dangerous-politicization-endocrinologists-gender-affirming-care-arkansas-dac768bd?mod=article_inline)

<sup>9</sup><https://threadreaderapp.com/thread/1679603669010989057.html>

<sup>10</sup><https://thehill.com/opinion/healthcare/4070174-why-europe-and-america-are-going-in-opposite-directions-on-youth-transgender-medicine/>

<sup>11</sup><https://thehill.com/opinion/healthcare/4070174-why-europe-and-america-are-going-in-opposite-directions-on-youth-transgender-medicine/>

<sup>12</sup><https://static1.squarespace.com/static/56a45d683b0be33df885def6/t/6602fa875978a01601858171/1711471262073/WPATH+Report+and+Files111.pdf>

<sup>13</sup><https://www.wsj.com/articles/most-transgender-kids-turn-out-to-be-gay-gender-affirming-care-conversion-therapy-58111b2e>

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## The Evidence Hierarchy

The hierarchy of evidence is a core principal of EBM. EBM hierarchies rank study types based on the strength and precision of their research methods. Different hierarchies exist for different question types, and even experts may disagree on the exact rank of information in the evidence hierarchies. Still, most agree that current, well designed systematic reviews and meta-analyses are at the top of the pyramid, and that expert opinion and anecdotal experience are at the bottom.

### The Evidence Hierarchy, Questions about Treatment

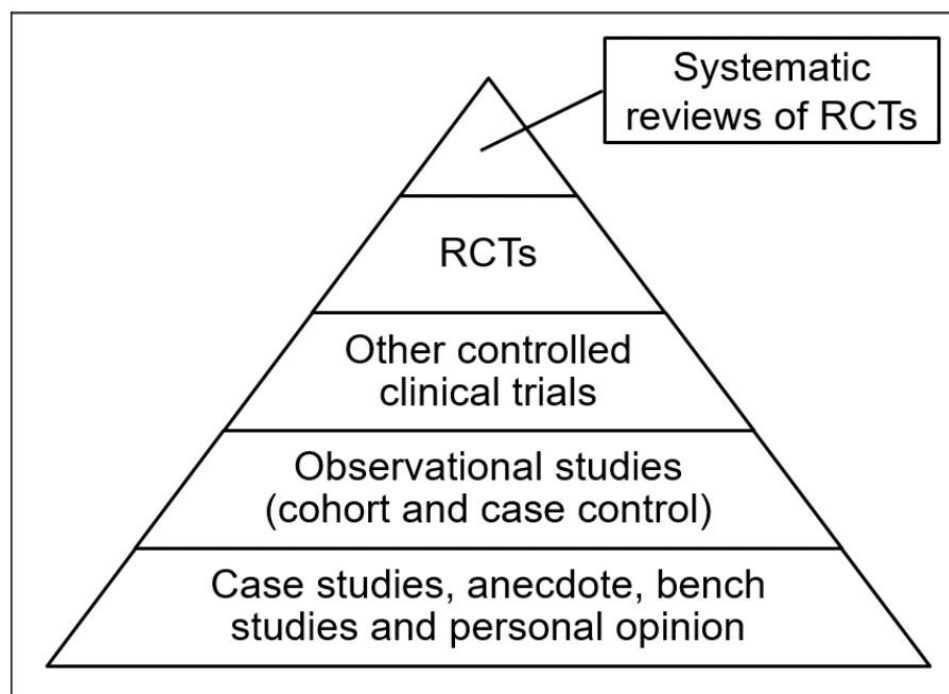


Figure adapted from Greenhalgh T. How to Read a Paper: The Basics of Evidence-Based Medicine. Hoboken: John Wiley & Sons, Incorporated; 2010.

Figure 2.1 A simple hierarchy of evidence for assessing the quality of trial design in therapy studies.

Intended for healthcare professionals



**Feature** BMJ Investigation

# Gender dysphoria in young people is rising—and so is professional disagreement

BMJ 2023; 380 doi: <https://doi.org/10.1136/bmj.p382> (Published 23 February 2023)

Cite this as: BMJ 2023;380:p382

## Linked Feature

Gender identity services in the UK are on pause as evidence comes under scrutiny

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More children and adolescents are identifying as transgender and are being offered medical treatment, especially in the US—but some providers and European authorities are urging caution because of a lack of strong evidence.

**Jennifer Block** reports

Last October the American Academy of Pediatrics (AAP) gathered inside the Anaheim Convention Center in California for its annual conference. Outside, several dozen people rallied to hear speakers including Abigail Martinez, a mother whose child began hormone treatment at age 16 and died by suicide at age 19. Supporters chanted the teen's given name, Yaeli; counter protesters chanted, "Protect trans youth!" For viewers on a livestream, the feed was interrupted as the two groups fought for the camera.

The AAP conference is one of many flashpoints in the contentious debate in the United States over if, when, and how children and adolescents with gender dysphoria should be medically or surgically treated. US medical professional groups are aligned in support of "gender affirming care" for gender dysphoria, which may include gonadotrophin releasing hormone analogues (GnRHa) to suppress puberty; oestrogen or testosterone to promote secondary sex characteristics; and surgical removal or augmentation of breasts, genitals, or other physical features. At the same time, however, several European countries have issued guidance to limit medical intervention

in minors, prioritising psychological care.

The discourse is polarised in the US. Conservative politicians, pundits, and social media influencers accuse providers of pushing “gender ideology” and even “child abuse,” lobbying for laws banning medical transition for minors. Progressives argue that denying access to care is a transphobic violation of human rights. There’s little dispute within the medical community that children in distress need care, but concerns about the rapid widespread adoption of interventions and calls for rigorous scientific review are coming from across the ideological spectrum.<sup>1</sup>

## The surge in treatment of minors

More adolescents with no history of gender dysphoria—predominantly birth registered females<sup>2</sup>—are presenting at gender clinics. A recent analysis of insurance claims by Komodo Health found that nearly 18000 US minors began taking puberty blockers or hormones from 2017 to 2021, the number rising each year.<sup>3</sup> Surveys aiming to measure prevalence have found that about 2% of high school aged teens identify as “transgender.”<sup>5</sup> These young people are also more likely than their cisgender peers to have concurrent mental health and neurodiverse conditions including depression, anxiety, attention deficit disorders, and autism.<sup>6</sup> In the US, although Medicaid coverage varies by state and by treatment, the Biden administration has warned states that not covering care is in violation of federal law prohibiting discrimination.<sup>7</sup> Meanwhile, the number of private clinics that focus on providing hormones and surgeries has grown from just a few a decade ago to more than 100 today.<sup>4</sup>

As the number of young people receiving medical transition treatments rises, so have the voices of those who call themselves “detransitioners” or “retransitioners,” some of whom claim that early treatment caused preventable harm.<sup>8</sup> Large scale, long term research is lacking,<sup>9</sup> and researchers disagree about how to measure the phenomenon, but two recent studies suggest that as many as 20-30% of patients may discontinue hormone treatment within a few years.<sup>10</sup><sup>11</sup> The World Professional Association for Transgender Health (WPATH) asserts that detransition is “rare.”<sup>12</sup>

Chloe Cole, now aged 18, had a double mastectomy at age 15 and spoke at the AAP rally. “Many of us were young teenagers when we decided, on the direction of medical experts, to pursue irreversible hormone treatments and surgeries,” she read from her tablet at the rally, which had by this time moved indoors to avoid confrontation. “This is not informed consent but a decision forced under extreme duress.”

Scott Hadland, chief of adolescent medicine at Massachusetts General Hospital and Harvard Medical School, dismissed the “handful of cruel protesters” outside the AAP meeting in a tweet that morning. He wrote, “Inside 10 000 pediatricians stand in solidarity for trans & gender diverse kids & their families to receive evidence-based, lifesaving, individualized care.”<sup>13</sup>

## Same evidence, divergent recommendations

Three organisations have had a major role in shaping the US’s approach to gender dysphoria care: WPATH, the AAP, and the Endocrine Society (see box). On 15 September 2022 WPATH published the eighth edition of its Standards of Care for the Health of Transgender and Gender Diverse People, with new chapters on children and



adolescents and no minimum age requirements for hormonal and surgical treatments.<sup>21</sup> GnRHa treatment, says WPATH, can be initiated to arrest puberty at its earliest stage, known as Tanner stage 2.

The Endocrine Society also supports hormonal and surgical intervention in adolescents who meet criteria in clinical practice guidelines published in 2009 and updated in 2017.<sup>14</sup> And the AAP's 2018 policy statement, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, says that “various interventions may be considered to better align” a young person’s “gender expression with their underlying identity.”<sup>15</sup> Among the components of “gender affirmation” the AAP names social transition, puberty blockers, sex hormones, and surgeries. Other prominent professional organisations, such as the American Medical Association, have issued policy statements in opposition to legislation that would curtail access to medical treatment for minors.<sup>16</sup><sup>17</sup><sup>18</sup><sup>19</sup>

These documents are often cited to suggest that medical treatment is both uncontroversial and backed by rigorous science. “All of those medical societies find such care to be evidence-based and medically necessary,” stated a recent article on transgender healthcare for children published in *Scientific American*.<sup>20</sup> “Transition related healthcare is not controversial in the medical field,” wrote Gillian Branstetter, a frequent spokesperson on transgender issues currently with the American Civil Liberties Union, in a 2019 guide for reporters.<sup>21</sup> Two physicians and an attorney from Yale recently opined in the *Los Angeles Times* that “gender-affirming care is standard medical care, supported by major medical organizations . . . Years of study and scientific scrutiny have established safe, evidence-based guidelines for delivery of lifesaving, gender-affirming care.”<sup>22</sup> Rachel Levine, the US assistant secretary for health, told National Public Radio last year regarding such treatment, “There is no argument among medical professionals.”<sup>23</sup>

Internationally, however, governing bodies have come to different conclusions regarding the safety and efficacy of medically treating gender dysphoria. Sweden’s National Board of Health and Welfare, which sets guidelines for care, determined last year that the risks of puberty blockers and treatment with hormones “currently outweigh the possible benefits” for minors.<sup>24</sup> Finland’s Council for Choices in Health Care, a monitoring agency for the country’s public health services, issued similar guidelines, calling for psychosocial support as the first line treatment.<sup>25</sup> (Both countries restrict surgery to adults.)

Medical societies in France, Australia, and New Zealand have also leant away from early medicalisation.<sup>26</sup><sup>27</sup> And NHS England, which is in the midst of an independent review of gender identity services, recently said that there was “scarce and inconclusive evidence to support clinical decision making”<sup>28</sup> for minors with gender dysphoria<sup>29</sup> and that for most who present before puberty it will be a “transient phase,” requiring clinicians to focus on psychological support and to be “mindful” even of the risks of social transition.<sup>30</sup>

#### **Box The origins of paediatric gender medicine in the United States**

The World Professional Association for Transgender Health (WPATH) began as a US based advocacy group and issued the first edition of the Standards of Care in 1979, when it was serving a small population of mostly adult male-to-female transsexuals. “WPATH became the standard because there was nobody else doing it,” says Erica Anderson, a California based clinical psychologist and former WPATH board member. The professional US organisations that lined up in support “looked heavily to WPATH and the Endocrine Society

for their guidance,” she told *The BMJ*.

The Endocrine Society’s guidance for adolescents grew out of clinicians’ research in the Netherlands in the late 1990s and early 2000s. Peggy Cohen-Kettenis, a Utrecht gender clinic psychologist, collaborated with endocrinologists in Amsterdam, one of whom had experience of prescribing gonadotrophin releasing hormone analogues, relatively new at the time. Back then, gender dysphoric teens had to wait until the age of majority for sex hormones, but the team proposed that earlier intervention could benefit carefully selected minors.<sup>40</sup>

The clinic treated one natal female patient with triptorelin, published a case study and feasibility proposal, and began treating a small number of children at the turn of the millennium. The Dutch Protocol was published in 2006, referring to 54 children whose puberty was being suppressed and reporting preliminary results on the first 21.<sup>41</sup> The researchers received funding from Ferring Pharmaceuticals, the manufacturer of triptorelin.

In 2007 the endocrinologist Norman Spack began using the protocol at Boston Children’s Hospital and joined Cohen-Kettenis and her Dutch colleagues in writing the Endocrine Society’s first clinical practice guideline.<sup>42</sup> When that was published in 2009, puberty had been suppressed in just over 100 gender dysphoric young people.<sup>40</sup>

American Academy of Pediatrics (AAP) committee members began discussing the need for a statement in 2014, four years before publication, says Jason Rafferty, assistant professor of paediatrics and psychiatry at Brown University, Rhode Island, and the statement’s lead author. “The AAP recognised that it had a responsibility to provide some clinical guidance, but more importantly to come out with a statement that said we need research, we need to integrate the principles of gender affirmative care into medical education and into child health,” he says. “What our policy statement is not meant to be is a protocol or guidelines in and of themselves.”

## “Don’t call them evidence based”

“The brief history of guidelines is that, going back more than 30 years ago, experts would write articles and so on about what people should do. But formal guidelines as we think of them now were seldom or non-existent,” says Gordon Guyatt, distinguished professor in the Department of Health Research Methods, Evidence, and Impact at McMaster University, Ontario.

That led to the movement towards developing criteria for what makes a “trustworthy guideline,” of which Guyatt was a part.<sup>31</sup> One pillar of this, he told *The BMJ*, is that they “are based on systematic review of the relevant evidence,” for which there are also now standards, as opposed to a traditional narrative literature review in which “a bunch of experts write whatever they felt like using no particular standards and no particular structure.”

Mark Helfand, professor of medical informatics and clinical epidemiology at Oregon Health and Science University, says, “An evidence based recommendation requires two steps.” First, “an unbiased, thorough, critical systematic review of all the relevant evidence.” Second, “some commitment to link the strength of the recommendations to

the quality of the evidence.”

The Endocrine Society commissioned two systematic reviews for its clinical practice guideline, *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*: one on the effects of sex steroids on lipids and cardiovascular outcomes, the other on their effects on bone health.<sup>3233</sup> To indicate the quality of evidence underpinning its various guidelines, the Endocrine Society employed the GRADE system (grading of recommendations assessment, development, and evaluation) and judged the quality of evidence for all recommendations on adolescents as “low” or “very low.”

Guyatt, who co-developed GRADE, found “serious problems” with the Endocrine Society guidelines, noting that the systematic reviews didn’t look at the effect of the interventions on gender dysphoria itself, arguably “the most important outcome.” He also noted that the Endocrine Society had at times paired strong recommendations—phrased as “we recommend”—with weak evidence. In the adolescent section, the weaker phrasing “we suggest” is used for pubertal hormone suppression when children “first exhibit physical changes of puberty”; however, the stronger phrasing is used to “recommend” GnRHa treatment.

“GRADE discourages strong recommendations with low or very low quality evidence except under very specific circumstances,” Guyatt told *The BMJ*. Those exceptions are “very few and far between,” and when used in guidance, their rationale should be made explicit, Guyatt said. In an emailed response, the Endocrine Society referenced the GRADE system’s five exceptions, but did not specify which it was applying.

Helfand examined the recently updated WPATH Standards of Care and noted that it “incorporated elements of an evidence based guideline.” For one, WPATH commissioned a team at Johns Hopkins University in Maryland to conduct systematic reviews.<sup>3435</sup> However, WPATH’s recommendations lack a grading system to indicate the quality of the evidence—one of several deficiencies. Both Guyatt and Helfand noted that a trustworthy guideline would be transparent about all commissioned systematic reviews: how many were done and what the results were. But Helfand remarked that neither was made clear in the WPATH guidelines and also noted several instances in which the strength of evidence presented to justify a recommendation was “at odds with what their own systematic reviewers found.”

For example, one of the commissioned systematic reviews found that the strength of evidence for the conclusions that hormonal treatment “may improve” quality of life, depression, and anxiety among transgender people was “low,” and it emphasised the need for more research, “especially among adolescents.”<sup>35</sup> The reviewers also concluded that “it was impossible to draw conclusions about the effects of hormone therapy” on death by suicide.

Despite this, WPATH recommends that young people have access to treatments after comprehensive assessment, stating that the “emerging evidence base indicates a general improvement in the lives of transgender adolescents.”<sup>12</sup> And more globally, WPATH asserts, “There is strong evidence demonstrating the benefits in quality of life and well-being of gender-affirming treatments, including endocrine and surgical procedures,” procedures that “are based on decades of clinical experience and research; therefore, they are not considered experimental, cosmetic, or for the mere convenience of a patient. They are safe and effective at reducing gender incongruence and gender dysphoria.”<sup>12</sup>

Those two statements are each followed by more than 20 references, among them the commissioned systematic review. This stood out to Helfand as obscuring which conclusions were based on evidence versus opinion. He says, “It’s a very strange thing to feel that they had to cite some of the studies that would have been in the systematic review or purposefully weren’t included in the review, because that’s what the review is for.”

For minors, WPATH contends that the evidence is so limited that “a systematic review regarding outcomes of treatment in adolescents is not possible.” But Guyatt counters that “systematic reviews are always possible,” even if few or no studies meet the eligibility criteria. If an entity has made a recommendation without one, he says, “they’d be violating standards of trustworthy guidelines.” Jason Rafferty, assistant professor of paediatrics and psychiatry at Brown University, Rhode Island, and lead author of the AAP statement, remarks that the AAP’s process “doesn’t quite fit the definition of systematic review, but it is very comprehensive.”

Sweden conducted systematic reviews in 2015 and 2022 and found the evidence on hormonal treatment in adolescents “insufficient and inconclusive.”<sup>24</sup> Its new guidelines note the importance of factoring the possibility that young people will detransition, in which case “gender confirming treatment thus may lead to a deteriorating of health and quality of life (i.e., harm).”

Cochrane, an international organisation that has built its reputation on delivering independent evidence reviews, has yet to publish a systematic review of gender treatments in minors. But *The BMJ* has learnt that in 2020 Cochrane accepted a proposal to review puberty blockers and that it worked with a team of researchers through 2021 in developing a protocol, but it ultimately rejected it after peer review. A spokesperson for Cochrane told *The BMJ* that its editors have to consider whether a review “would add value to the existing evidence base,” highlighting the work of the UK’s National Institute for Health and Care Excellence, which looked at puberty blockers and hormones for adolescents in 2021. “That review found the evidence to be inconclusive, and there have been no significant primary studies published since.”

In 2022 the state of Florida’s Agency for Health Care Administration commissioned an overview of systematic reviews looking at outcomes “important to patients” with gender dysphoria, including mental health, quality of life, and complications. Two health research methodologists at McMaster University carried out the work, analysing 61 systematic reviews and concluding that “there is great uncertainty about the effects of puberty blockers, cross-sex hormones, and surgeries in young people.” The body of evidence, they said, was “not sufficient” to support treatment decisions.

Calling a treatment recommendation “evidence based” should mean that a treatment has not just been systematically studied, says Helfand, but that there was also a finding of high quality evidence supporting its use. Weak evidence “doesn’t just mean something esoteric about study design, it means there’s uncertainty about whether the long term benefits outweigh the harms,” Helfand adds.

“Evidence itself never tells you what to do,” says Guyatt. That’s why guidelines must make explicit the values and preferences that underlie the recommendation.

The Endocrine Society acknowledges in its recommendations on early puberty suppression that it is placing “a high value on avoiding an unsatisfactory physical outcome when secondary sex characteristics have become

manifest and irreversible, a higher value on psychological well-being, and a lower value on avoiding potential harm.”<sup>14</sup>

WPATH acknowledges that while its latest guidelines are “based upon a more rigorous and methodological evidence-based approach than previous versions,” the evidence “is not only based on the published literature (direct as well as background evidence) but also on consensus-based expert opinion.” In the absence of high quality evidence and the presence of a patient population in need—who are willing to take on more personal risk—consensus based guidelines are not unwarranted, says Helfand. “But don’t call them evidence based.”

## An evidence base under construction

In 2015 the US National Institutes of Health awarded a \$5.7m (£4.7m; €5.3m) grant to study “the impact of early medical treatment in transgender youth.”<sup>36</sup> The abstract submitted by applicants said that the study was “the first in the US to evaluate longitudinal outcomes of medical treatment for transgender youth and will provide essential evidence-based data on the physiological and psychosocial effects and safety” of current treatments. Researchers are following two groups, one of participants who began receiving GnRHa in early puberty and another group who began cross sex hormone treatment in adolescence. The study doesn’t include a concurrent no-treatment control group.

Robert Garofalo, chief of adolescent medicine at the Lurie Children’s Hospital in Chicago and one of four principal investigators, told a podcast interviewer in May 2022 that the evidence base remained “a challenge . . . it is a discipline where the evidence base is now being assembled” and that “it’s truly lagging behind [clinical practice], I think, in some ways.” That care, he explained, was “being done safely. But only now, I think, are we really beginning to do the type of research where we’re looking at short, medium, and long term outcomes of the care that we are providing in a way that I think hopefully will be either reassuring to institutions and families and patients or also will shed a light on things that we can be doing better.”<sup>37</sup>

While Garofalo was doing the research he served as “contributor” on the AAP’s widely cited 2018 policy statement, which recommends that children and adolescents “have access to comprehensive, gender-affirming, and developmentally appropriate health care,” including puberty blockers, sex hormones, and, on a case-by-case basis, surgeries.<sup>15</sup>

Garofalo said in the May interview, “There is universal support for gender affirming care from every mainstream US based medical society that I can think of: the AMA, the APA, the AAP. I mean, these organisations never agree with one another.” Garofalo declined an interview and did not respond to *The BMJ*’s requests for comment.

## The rush to affirm

Sarah Palmer, a paediatrician in private practice in Indiana, is one of five coauthors of a 2022 resolution submitted to the AAP’s leadership conference asking that it revisit the policy after “a rigorous systematic review of available evidence regarding the safety, efficacy, and risks of childhood social transition, puberty blockers, cross sex hormones and surgery.” In practice, Palmer told *The BMJ*, clinicians define “gender affirming” care so broadly that “it’s been taken by many people to mean go ahead and do anything that affirms. One of the main things I’ve seen

it used for is masculinising chest surgery, also known as mastectomy in teenage patients.” The AAP has told *The BMJ* that all policy statements are reviewed after five years and so a “revision is under way,” based on its experts’ own “robust evidence review.”

Palmer says, “I’ve seen a quick evolution, from kids with a very rare case of gender dysphoria who were treated with a long course of counselling and exploration before hormones were started,” to treatment progressing “very quickly—even at the first visit to gender clinic—and there’s no psychologist involved anymore.”

Laura Edwards-Leeper, a clinical psychologist who worked with the endocrinologist Norman Spack in Boston and coauthored the WPATH guidelines for adolescents, has observed a similar trend. “More providers do not value the mental health component,” she says, so in some clinics families come in and their child is “pretty much fast tracked to medical intervention.” In a study of teens at Seattle Children’s Hospital’s gender clinic, two thirds were taking hormones within 12 months of the initial visit.<sup>38</sup>

The British paediatrician Hilary Cass, in her interim report of a UK review into services for young people with gender identity issues, noted that some NHS staff reported feeling “under pressure to adopt an unquestioning affirmative approach and that this is at odds with the standard process of clinical assessment and diagnosis that they have been trained to undertake in all other clinical encounters.”

Eli Coleman, lead author of WPATH’s Standards of Care and former director of the Institute for Sexual and Gender Health at the University of Minnesota, told *The BMJ* that the new guidelines emphasised “careful assessment prior to any of these interventions” by clinicians who have appropriate training and competence to assure that minors have “the emotional and cognitive maturity to understand the risks and benefits.” He adds, “What we know and what we don’t know has to be explained to youth and their parents or caregivers in a balanced way which really details that this is the evidence that we have, that we obviously would like to have more evidence, and that this is a risk-benefit scenario that you have to consider.”

Joshua Safer, director of the Center for Transgender Medicine and Surgery at Mount Sinai Hospital in New York and coauthor of the Endocrine Society guidelines, told *The BMJ* that assessment is standard practice at the programme he leads. “We start with a mental health evaluation for anybody under the age of 18,” he says. “There’s a lot of talking going on—that’s a substantial element of things.” Safer has heard stories of adolescents leaving a first or second appointment with a prescription in hand but says that these are overblown. “We really do screen these kids pretty well, and the overwhelming majority of kids who get into these programmes do go on to other interventions,” he says.

Without an objective diagnostic test, however, others remain concerned. The demand for services has led to a “perfunctory informed consent process,” wrote two clinicians and a researcher in a recent issue of the *Journal of Sex and Marital Therapy*,<sup>39</sup> in spite of two key uncertainties: the long term impacts of treatment and whether a young person will persist in their gender identity. And the widespread impression of medical consensus doesn’t help. “Unfortunately, gender specialists are frequently unfamiliar with, or discount the significance of, the research in support of these two concepts,” they wrote. “As a result, the informed consent process rarely adequately discloses this information to patients and their families.”



For Guyatt, claims of certainty represent both the success and failure of the evidence based medicine movement. “Everybody now has to claim to be evidence based” in order to be taken seriously, he says—that’s the success. But people “don’t particularly adhere to the standard of what is evidence based medicine—that’s the failure.” When there’s been a rigorous systematic review of the evidence and the bottom line is that “we don’t know,” he says, then “anybody who then claims they do know is not being evidence based.”

## Footnotes

- This feature has been funded by the BMJ Investigations Unit. For details see [bmj.com/investigations](https://www.bmj.com/investigations).
- Competing interests: I have read and understood BMJ policy on declaration of interests and have no relevant interests to declare.
- Provenance: commissioned; externally peer reviewed.

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What would be the most appropriate replacement for the term junior doctors in the UK?

- Postgraduate doctors
- Doctors
- Doctors in training
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- Non-consultant doctor
- Attending/Resident
- None -- junior doctors is the correct term
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## The Evidence Hierarchy

The hierarchy of evidence is a core principal of EBM. EBM hierarchies rank study types based on the strength and precision of their research methods. Different hierarchies exist for different question types, and even experts may disagree on the exact rank of information in the evidence hierarchies. Still, most agree that current, well designed systematic reviews and meta-analyses are at the top of the pyramid, and that expert opinion and anecdotal experience are at the bottom.

### The Evidence Hierarchy, Questions about Treatment

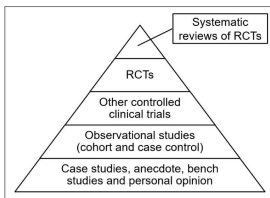


Figure adapted from Greenhalgh T. How to Read a Paper: The Basics of Evidence-Based Medicine. Hoboken: John Wiley & Sons, Incorporated; 2010. Figure 2.1 A simple hierarchy of evidence for assessing the quality of trial design in therapy studies.

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## Systematic Reviews

A **systematic review** is "a review that uses explicit, systematic methods to collate and synthesise findings of studies that address a clearly formulated question".<sup>1</sup>

Systematic reviews are useful for:

- confirming current practices
- guiding decision-making
- informing future research

**Meta-analyses**, while often part of systematic reviews, are not interchangeable with them. They use statistical analysis to combine data from the studies found in the systematic review process. These studies must be homogenous enough that the data from them can be pooled together.

Limitations of systematic reviews include:

- That since they are focused on a clearly formulated question, their conclusions only answer that particular question and cannot be generalized
- That the synthesis of materials is only as reliable as the primary studies the review analyzed

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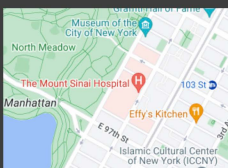
## Primary Studies

In the absence of a current, well designed systematic review is not available, practitioners turn to the primary studies to answer their questions. The best research design depends on the question type. The table below lists optimal study methodologies for common types of clinical questions.

Question Type	Optimal Study Methodology
<b>Treatment (Therapy) &amp; Prevention</b>	<ul style="list-style-type: none"> <li>• Randomized controlled trial (RCT)</li> </ul>
<b>Diagnosis</b>	<ul style="list-style-type: none"> <li>• Randomized controlled trial (RCT)</li> <li>• Crossover study: Subjects receive both the intervention (diagnostic test) under investigation and the reference standard or "gold standard" diagnostic test</li> </ul>
<b>Prognosis (Natural History)</b>	<ul style="list-style-type: none"> <li>• Cohort study</li> </ul>
<b>Etiology or Harm (Causation)</b>	<ul style="list-style-type: none"> <li>• Randomized controlled trial (RCT)</li> <li>• If RCTs are impractical or unethical, cohort study or case control study</li> </ul>

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# Why Europe and America are going in opposite directions on youth transgender medicine

BY LEOR SAPIR, OPINION CONTRIBUTOR - 06/28/23 2:00 PM ET

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A growing number of countries, including some of the most progressive in Europe, are rejecting the U.S. “gender-affirming” model of care for transgender-identified youth. These countries have adopted a far more restrictive and cautious approach, one that prioritizes psychotherapy and reserves hormonal interventions for extreme cases.

In stark contrast to groups like the American Academy of Pediatrics (AAP), which urges clinicians to “affirm” their patient’s identity irrespective of circumstance and regards alternatives to an affirm-early/affirm-only approach “conversion therapy,” European health authorities are recommending exploratory therapy to discern why teens are rejecting their bodies and whether less invasive treatments may help.

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If implemented in American clinics, the European approach would effectively deny puberty blockers and cross-sex hormones to most adolescents who are receiving these drugs today. Unlike in the U.S., in Europe surgeries are generally off the table before adulthood. ✕

A bedrock principle of EBM is that medical recommendations should be grounded in the best available research. EBM recognizes a hierarchy of information. The expert opinion of doctors, for example, even when based on extensive clinical experience, furnishes the lowest quality — meaning, least reliable — information. Slightly higher on the information pyramid are observational studies. Systematic reviews of evidence, meanwhile, furnish the highest quality evidence. They follow a rigorously developed, reproducible methodology. They do not cherry-pick studies with convenient results, but instead consider all the available research.

Most importantly, systematic reviews don't merely summarize the conclusions of available studies on a question of interest. Instead, they assess the strengths and weaknesses of these studies to determine the reliability of their findings. To do this, systematic reviews typically use the GRADE system (Grading of Recommendations, Assessment, Development and Evaluations) and rank the quality of evidence as “high,” “moderate,” “low” or “very low.”

Systematic reviews by EBM experts in Scandinavia and the United Kingdom have concluded that there are serious gaps in the evidence base for sex modification in minors. The U.K. systematic reviews found the available research to be of “very low” quality — meaning that there is very low certainty that an observed effect, like reduced suicidality, is due to the intervention, and therefore the studies' claimed results are unlikely to represent the truth.

Importantly, even the famous Dutch study that is said to be the “gold standard” of research in this area received a rating of “very low” due to serious methodological problems. Sweden's National Board of Health and Welfare has said that the risks of treating gender dysphoric minors with hormonal interventions “currently outweigh the possible benefits.”

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Last year, Florida’s health authorities commissioned what is known as an “umbrella review,” or a systematic overview of systematic reviews, from independent experts at McMaster University, home of EBM. Unsurprisingly, [that overview](#) came to the same conclusion: There is no reliable evidence that youth transition improves mental health outcomes.

Because U.S. medical groups [don’t always use EBM](#), their conclusions can be based on studies whose fatal flaws are overlooked or ignored. Consider, as an example, [a study done at Seattle Children’s Hospital](#) and published last year. The study’s authors reported that use of puberty blockers and cross-sex hormones was associated with 60 percent lower odds of depression and 73 percent lower odds of suicidality. Leading mainstream publications, including [Scientific American](#) and [Psychology Today](#), celebrated the findings. More recently, major U.S. medical associations [cited the study](#) in federal court proceedings.

But a [careful look](#) at the study’s data shows that the kids who received hormonal interventions did no better by the end of the study than at the beginning. The researchers’ claim about improvement was based on the fact that the kids in the control group, who received psychotherapy but not hormones, got worse relative to the hormone group. But even this isn’t accurate, as 80 percent of the control group dropped out by the end of the study, and a likely reason for this dramatic loss to follow-up is that many or perhaps all of the non-hormone-treated kids improved without “gender-affirming” drugs. It’s quite ✕

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Similar problems exist in studies purporting to show a rate of transition regret of less than 1 percent. The true rate of regret is not known and won't be known for years to come. The claim that gender dysphoric teens are at high risk of suicide if not given access to "gender-affirming" drugs and surgeries is likewise baseless and irresponsible. In February, Finland's top expert in gender medicine emphasized this point to the country's liberal newspaper of record.

The American Academy of Pediatrics' main statement on gender medicine, authored by a single doctor while still in his residency, is not a systematic review. The author himself has conceded as much. A later published peer-reviewed fact check found the AAP statement to be a textbook example of cherry-picking and mischaracterization of evidence.

The World Professional Association of Transgender Health (WPATH) says in its latest "standards of care" that a systematic review of evidence is "not possible." Instead, WPATH used a "narrative review," which has a high risk of bias according to EBM because it doesn't utilize a reproducible methodology. England has broken from WPATH, and the director of Belgium's Center for Evidence-Based Medicine has said he would "toss them [WPATH's guidelines] in the bin." In the U.S., WPATH's standards are widely accepted as authoritative.

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The U.S. Endocrine Society has relied on two systematic reviews in developing its own guideline. But these reviews were not for mental health benefits, and in any case the Endocrine Society ranks the quality of evidence behind its own recommendations as “low” or “very low.”

All other U.S. medical groups cite these three sources when assuring the public about “gender-affirming care,” thus creating an illusion of consensus around “settled science.”

Earlier this year, an investigative report in the prestigious British Medical Journal concluded that although pediatric gender medicine in the U.S. is “consensus-based,” it is not “evidence-based.” Gordon Guyatt, distinguished professor in the Department of Health Research Methods, Evidence, and Impact at McMaster University, Ontario, and one of the founders of EBM, recently called American guidelines for managing youth gender dysphoria “untrustworthy.”

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Consensus can be produced by misguided empathy, ideological capture or political pressures. Consensus can also be manufactured. The new president of the American Medical Association (AMA) has said there should be “no debate” when it comes to offering kids “gender-affirming” drugs and surgeries.

Yale School of Medicine’s Dr. Meredith McNamara calls the questioning of the evidence behind pediatric sex changes “science denialism.” Her protest is ironic. Science is a process of ongoing inquiry and debate, not a set of predetermined conclusions. Science depends on skepticism, especially about sensitive subjects. True science denialism means restricting rational, evidence-based debate — exactly what McNamara and the AMA’s new president want to do.

Their calls are bearing fruit. Just this month, gender activists successfully pressured a medical journal to retract a paper whose conclusions they found inconvenient. The ongoing campaign to suppress scientific debate allows a pseudo-consensus to emerge around “gender-affirming care.”

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Put simply, pediatric gender medicine in the U.S. is out of control. Medicalization of gender diversity in children is a fast-growing industry that shows no signs of self-correction. Doctors and therapists who practice “affirmative” medicine consistently demonstrate ignorance about EBM principles and deceive the public about the grim realities behind the euphemism “gender-affirming care.”

A Reuters investigation last year interviewed providers at 18 pediatric gender clinics and found that none were doing comprehensive mental health assessments and differential diagnosis. Those who promote and practice “gender-affirming care” themselves tell us that their approach is child-led. “Gatekeeping” of medical transition, they insist, is pointless, even “dehumanizing.”

The author of the AAP’s position paper on gender medicine has said that a “child’s sense of reality” is the “navigational beacon to orient treatment around.” The director of the gender clinic at Boston Children’s Hospital has admitted that they give out puberty blockers “like candy.” Even the founding psychologist of that clinic has warned that kids are being inappropriately “rushed toward the medical model.”

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Why the U.S. has become an outlier on pediatric transgender medicine is a complicated question, but at least part of the answer is that European welfare states have centralized health bureaucracies and public health insurance. Before medicines can be approved for state funding, their evidence base needs to be evaluated. The American health care system is more vulnerable to profit motives, activist doctors and political pressures. [Medical associations](#) claim to advocate for patient health but [can have other motives](#) as well.

The situation is so dire that when pediatric gender medicine experts in other countries want to defend their practices before a skeptical public, [they sometimes say](#) that at least they are not as bad as the Americans. That is one kind of American exceptionalism we can do without.

*Leor Sapir is a fellow at the Manhattan Institute.*

**TAGS** EUROPE EVIDENCE-BASED MEDICINE GENDER GENDER-AFFIRMING CARE  
HEALTHCARE MEDICINE TRANSGENDER YOUTH

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# The WPATH Files

PSEUDOSCIENTIFIC SURGICAL AND HORMONAL  
EXPERIMENTS ON CHILDREN,  
ADOLESCENTS, AND VULNERABLE ADULTS

By Mia Hughes



**ENVIRONMENTAL  
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## EXECUTIVE SUMMARY

The World Professional Association for Transgender Health (WPATH) enjoys the reputation of being the leading scientific and medical organization devoted to transgender healthcare. WPATH is globally recognized as being at the forefront of gender medicine.

However, throughout this report, we will show that the opposite is true. Newly released files from WPATH's internal messaging forum, as well as a leaked internal panel discussion, demonstrate that the world-leading transgender healthcare group is neither scientific nor advocating for ethical medical care. These internal communications reveal that WPATH advocates for many arbitrary medical practices, including hormonal and surgical experimentation on minors and vulnerable adults. Its approach to medicine is consumer-driven and pseudoscientific, and its members appear to be engaged in political activism, not science.

While there is a place in medicine for risky experiments, these can only be justified if there is a reliable, objective diagnosis; no other treatment options are available, and if the outcome for a patient or patient group is dire.<sup>1</sup> However, contrary to WPATH's claims, gender medicine does not fall into this category. The psychiatric condition of gender dysphoria is not a fatal illness, and the best available studies show that in the case of minors, with watchful waiting and compassionate support, most will either grow out of it or learn to manage their distress in ways less detrimental to their health.<sup>2,3,4</sup>

As such, this report will prove that sex-trait

modification procedures on minors and people with mental health disorders, known as "gender-affirming care," are unethical medical experiments. This experiment causes harm without justification, and its victims are some of society's most vulnerable people. Their injuries are painful and life-altering. WPATH-affiliated healthcare providers advocate for the destruction of healthy reproductive systems, the amputation of healthy breasts, and the surgical removal of healthy genitals as the first and only line of treatment for minors and mentally ill people with gender dysphoria, eschewing any attempt to reconcile the patient with his or her birth sex. This report will show that this is a violation of medical ethics and, as is revealed by its own internal communications, WPATH does not meet the standards of evidence-based medicine. It will further show that the ethical requirement to obtain informed consent is being violated, with members admitting that children and adolescents cannot comprehend the lifelong consequences of sex-trait modification interventions, and in some cases, due to poor health literacy, neither can their parents.

Given the extent of the medical malpractice WPATH endorses, our report will conclude by calling on the U.S. government to oversee a bipartisan national inquiry to investigate how activists with little respect for the Hippocratic Oath could have risen to such prominence as to set the Standards of Care for an entire field of medicine, leading to the medical abuse of minors and vulnerable adults.

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- 1 Earl, J. "Innovative Practice, Clinical Research, and the Ethical Advancement of Medicine." [In eng]. *Am J Bioeth* 19, no. 6 (Jun 2019): 7-18. <https://doi.org/10.1080/15265161.2019.1602175>.
  - 2 Singh, D., Bradley, S. J., & Zucker, K. J. (2021). A Follow-Up Study of Boys With Gender Identity Disorder [Original Research]. *Frontiers in Psychiatry*, 12, 287. <https://doi.org/10.3389/fpsy.2021.632784>
  - 3 Steensma, T., & Cohen-Kettenis, P. "Gender Transitioning before Puberty?." *Archives of sexual behavior* 40 (03/01 2011): 649-50. <https://doi.org/10.1007/s10508-011-9752-2>.
  - 4 Green, R. *The Sissy Boy Syndrome the Development of Homosexuality*. Yale University Press, 1987. doi:10.2307/j.ctt1ww3v4c. <http://www.jstor.org/stable/j.ctt1ww3v4c>.

## PREFACE TO THE WPATH FILES

By Michael Shellenberger, Founder and President, Environmental Progress

Readers may rightly wonder why an environmental organization is publishing a report on what is known as “gender medicine.” The short answer is that we are pro-human environmentalists, and our mission is to incubate ideas, leaders, and movements for nature, peace, and freedom for all. We thus work on a wide range of issues, from climate change to homelessness to freedom of speech, all of which constitute important aspects of our “environment.”

The longer answer is that I felt the WPATH Files needed to be analyzed and put in a broader historical context than possible through a series of news articles. I received the WPATH Files from a source or sources who contacted me because they had seen my work on the Twitter Files.

We are releasing all of the unedited files precisely as I received them. Nothing has been removed or added by our team, but we have organized the files to improve accessibility. We have included dates where available in the files. All discussions in the files occurred within the last four years. We are leaving only the names of the president of WPATH, most surgeons, and other prominent members unredacted. While everyone aware of the information revealed by the WPATH Files is, to some extent, responsible, we did not feel that everyone in the conversations needed to be named. The files are preceded

by a report that summarizes, analyzes, and draws implications from the information they contain.

The WPATH Files are semi-private conversations inside WPATH’s internal online forum for discussing specific medical cases. This forum runs on software provided by DocMatter. I made clear to the source or sources that while I welcomed all or any information they chose to share, I would not and did not solicit or encourage anyone to retrieve any information from WPATH or any other organization. All information came to me unsolicited.

We are well within our legal rights to publish the WPATH Files. Like any publisher, Environmental Progress is governed by what’s known as the Pentagon Papers Principle, established by the Supreme Court in 1971. Under the Court’s ruling, interpreting the First Amendment to the United States Constitution, Americans can publish information, even if it was obtained illegally, so long as we do not encourage anyone to break the law in obtaining the information.

At a moral level, we feel duty-bound to publish the WPATH Files and do everything within our power to encourage as wide an audience as possible to access them. We believe they show that WPATH is neither a scientific nor medical organization and should not be treated as one.

## ACKNOWLEDGMENTS

*The author would like to acknowledge, first and foremost, the source or sources of the WPATH Files. They behaved nobly in their effort to protect children and vulnerable adults from harm.*

*Second, she would like to acknowledge Alex Gutentag and Michael Shellenberger; their contributions to this report went far beyond editing.*

*Third, she would like to thank Lily Markle and Phoebe Smith for their fact-checking, proofing, and general assistance.*

*Finally, the author would like to thank the Environmental Progress Board of Directors and financial supporters. Thank you for thinking outside the box of “the environment” to extend your concern to vulnerable people everywhere.*



## INTRODUCTION

Over the past decade, there has been a huge surge in the number of young people identifying as transgender and being referred to pediatric and adult gender clinics. A thorough analysis of all the possible explanations for this change is beyond the scope of this report, but there are two opposing viewpoints worth describing briefly. On one side, activists argue that the sudden increase is due to shifting societal attitudes and greater acceptance of the transgender community, making it easier for transgender people to come out of the closet and live as their true, authentic selves. On the other side, critics of gender-affirming care for minors favor the rapid-onset gender dysphoria hypothesis, which argues that there is strong peer and online influence as well as maladaptive coping mechanisms involved in the adoption of a transgender identity.

This “social genesis” or “social contagion” argument is supported by the fact that adolescent girls and young women now make up most of the referrals to gender clinics when, in the past, it was predominantly young boys and adult men. Teenage girls and young women have been at the forefront of almost every social contagion in recorded history, including contagions of hysteria, eating disorders, cutting, and dissociative identity disorder. The social contagion argument is also supported by the high prevalence of mental health and neurocognitive disorders among trans-identified youth, and the fact that these problems typically precede the onset of gender issues.

Despite receiving criticism from activists, the rapid onset gender dysphoria theory has been endorsed by gender clinicians across the West.<sup>5,6,7</sup>

However, this report does not delve into the cultural factors responsible for the rising numbers. Instead, our focus narrows in on the conduct of WPATH members and the type of medical care the leading transgender health group endorses. The scope of this report is the potential harm inflicted upon adolescents and vulnerable adults within gender-affirming clinics.

WPATH is considered the leading authority on the care and treatment of individuals who have gender dysphoria and/or identify as transgender. WPATH publishes internationally respected Standards of Care, which it claims represent a professional consensus about the psychiatric, psychological, medical, and surgical management of gender dysphoria. Medical and mental health professionals worldwide look to these guidelines as the best available resource to guide them in caring for transgender and gender-diverse patients.

But the WPATH Files show something entirely different. Before discussing what they show, we recommend the reader turn to the files and read them in their entirety. They are complete from what a source or sources provided to us.

Now, we will put the WPATH Files in a wider historical and ethical context.

5 Hutchinson, A., Midgen, M., & Spiliadis, A. (2019). In Support of Research Into Rapid-Onset Gender Dysphoria. *Archives of Sexual Behavior*, 49. <https://doi.org/10.1007/s10508-019-01517-9>

6 Kaltiala, R. (2023). ‘Gender-Affirming Care Is Dangerous. I Know Because I Helped Pioneer It.’ *The Free Press*. <https://www.thefp.com/p/gender-affirming-care-dangerous-finland-doctor>

7 Levine, S. B. (2019). Informed Consent for Transgendered Patients. *J Sex Marital Ther*, 45(3), 218-229. <https://doi.org/10.1080/0092623x.2018.1518885>

## A BRIEF HISTORY OF TRANSGENDER MEDICINE AND THE EARLY DAYS OF WPATH

The experiment to modify the sex characteristics of people suffering from the psychiatric disorder called gender dysphoria began in the early years of the 20th century with the pioneering work of German sexologist Magnus Hirschfeld. A gay man who engaged in cross-dressing, Hirschfeld coined the term transvestite in his 1910 book *Die Transvestiten* and regarded both homosexuals and transvestites to be “sexual intermediaries.”<sup>8,9</sup>

Hirschfeld oversaw the world’s first attempt at “sex-reassignment” surgery performed on Martha/Karl Baer in 1906. While little is known about the precise nature of the surgery because the records were lost during the 1933 Nazi book-burning of Hirschfeld’s research,<sup>10,11</sup> it is believed to have been a metoidioplasty, which is the creation of a pseudo-phallus out of an enlarged clitoris. Baer is thought to have had a disorder of sexual development (DSD) and was reportedly genetically male.<sup>12,13</sup>

In 1919, Hirschfeld opened the Institute for Sexual Science in Berlin, which was a first-of-its-kind clinic providing counseling and treatment for “physical and psychological sexual disorders” as well as, in particular, for

“sexual transitions.”<sup>14</sup> Notably, Einar Wegener, or Lili Elbe, whose story was popularized in the film *The Danish Girl*, underwent surgical castration in Berlin under Hirschfeld’s supervision in 1930.<sup>15,16</sup> This was the first in a series of surgeries culminating in a womb transplant in 1931. Elbe died of heart failure three months after the final surgery, most likely due to organ rejection.<sup>17,18</sup>

That same year, Dora Richter underwent vaginoplasty, also under the care of Hirschfeld.<sup>19</sup> Erwin Gohrbandt performed Richter’s surgery, which is considered the world’s first successful male-to-female sex reassignment.<sup>20,21</sup> Gohrbandt then went on to join the Luftwaffe and participated in the hypothermia experiments conducted at Dachau concentration camp.<sup>22</sup>

Despite medical advances such as the development of antibiotics and the ability to create synthetic hormones, interest in sex-reassignment procedures waned over the next couple of decades, only to be rejuvenated in the 1950s with the sensational case of Christine Jorgensen.

On December 1, 1952, the New York Daily News ran a front-page story under the headline “Ex-GI Becomes

8 Matte, N. “International Sexual Reform and Sexology in Europe, 1897–1933.” *Canadian Bulletin of Medical History* 22, no. 2 (2005): 253-70. <https://doi.org/10.3138/cbmh.22.2.253>.

9 Hill, Darryl B. “Sexuality and Gender in Hirschfeld’s *Die Transvestiten*: A Case of the” Elusive Evidence of the Ordinary.” *Journal of the History of Sexuality* 14, no. 3 (2005): 316-32. <https://muse.jhu.edu/article/195723>.

10 “6 May 1933: Looting of the Institute of Sexology.” Holocaust Memorial Day Trust, <https://www.hmd.org.uk/resource/6-may-1933-looting-of-the-institute-of-sexology/>.

11 “Karl M Baer: First Transgender Person to Undergo Female-to-Male (Ftm) Surgery.” *Let Her Fly*, 2022, <https://letherfly.org/karl-m-baer-the-first-person-in-the-world-to-undergo-sex-change-surgery/>.

12 Funke, J. “The Case of Karl M.[Artha] Baer: Narrating ‘Uncertain’sex.” In *Sex, Gender and Time in Fiction and Culture*, 132-53: Springer, 2011.

13 “Recalling the First Sex Change Operation in History: A German-Israeli Insurance Salesman.” *Haaretz*, 2015, <https://www.haaretz.com/israel-news/2015-12-05/ty-article/.premium/the-first-sex-change-surgery-in-history/0000017f-f3fd-d5bd-a17f-f7fa4970000?ts=1698264422989>.

14 “The First Institute for Sexual Science (1919-1933).” Magnus-Hirschfeld-Gesellschaft, <https://magnus-hirschfeld.de/ausstellungen/institute/>.

15 “Publication History.” Lili Elbe Digital Archive, <http://lilielbe.org/narrative/publicationHistory.html>.

16 “Books of the Times; Radical Change and Enduring Love.” *The New York Times*, 2000, <https://www.nytimes.com/2000/02/14/books/books-of-the-times-radical-change-and-enduring-love.html>.

17 “Lili Elbe (Einar Wegener), 1882-1931.” *Danmarks Historien*, <https://danmarkshistorien.dk/vis/materiale/lili-elbe-einar-wegener-1882-1931/>

18 “Lili Elbe.” *Biography* 2022, <https://www.biography.com/artists/lili-elbe>.

19 Hirschfeld, [https://www.hirschfeld.in-berlin.de/institut/en/personen/pers\\_34.html](https://www.hirschfeld.in-berlin.de/institut/en/personen/pers_34.html).

20 Abraham, F. “Genital Reassignment on Two Male Transvestites.” *International Journal of Transgenderism* 2 (1998): 223-26. <https://editions-ismael.com/wp-content/uploads/2017/10/1931-Felix-Abraham-Genital-Reassignment-on-Two-Male-Transvestites.pdf>.

21 “Pioneers of Gender Reassignment Surgery.” *LGBT Health and Wellbeing*, <https://www.lgbthealth.org.uk/blog/pioneers-gender-reassignment-surgery/#:~:text=It%20was%20Dora%20Richter%20in,region%20to%20a%20poor%20family>.

22 “The Nazi Doctors and the Nuremberg Code.” Oxford University Press, 36. <http://www.columbia.edu/itc/history/rothman/COL47611854.pdf>.

Blonde Beauty.”<sup>23</sup> Jorgensen had traveled to Denmark the year before and, under the care of Dr. Christian Hamburger, underwent a series of surgeries involving castration and the creation of a semblance of external female genitalia.<sup>24,25,26</sup>

In 1953, after returning home to the US, Jorgensen became a patient of Dr. Harry Benjamin, a German endocrinologist with an interest in transsexualism, as it was known at the time.<sup>27</sup> Benjamin’s career in medicine had had a disreputable beginning when, in 1913, he arrived in New York as the assistant of a quack peddling “turtle treatment,” a fake tuberculosis vaccine.<sup>28</sup> Benjamin had no formal training in sexology, but as a lifelong friend of Hirschfeld, he had a fascination for the subject, and by the 1950s, his practice was almost exclusively focused on transsexualism.<sup>29</sup>

While Jorgensen brought fame and attention to Benjamin’s obscure interest in transsexualism, it was another patient who brought the other essential element: money. Reed (Rita) Erickson, a female who transitioned to live as a man, became Benjamin’s patient in 1963. Heir to a fortune, Erickson’s philanthropic organization, Erickson Educational Foundation (EEF), funded the first three International Symposiums on Gender Identity as well as the newly formed Harry Benjamin Foundation.<sup>30</sup> This enhanced Benjamin’s professional status, lending credibility to his sex change experiment. Benjamin coined

and popularized the term “transsexual” with his 1966 book, *The Transsexual Phenomenon*.

Another of Erickson’s philanthropic endeavors was to fund North America’s first gender clinic at Johns Hopkins Hospital in Baltimore.<sup>31</sup> It was at this clinic that Dr. John Money conducted his unethical experiments on children born with disorders of sexual development, the most famous case being that of the Reimer twins. As a baby, David Reimer was the victim of a catastrophic medical accident when the cauterizing equipment malfunctioned during his circumcision, amputating his penis. Money convinced David’s parents to raise him as a girl, an experiment that failed<sup>32</sup> and ultimately resulted in David committing suicide at age 38. His twin brother Brian had died two years previously of an overdose.

But Money didn’t just experiment on children. During the same period, he attempted to perform sex changes on adults, claiming great success. But when Dr. Paul McHugh became psychiatrist-in-chief at Johns Hopkins in 1975, he commissioned a follow-up study of the adults who had undergone these procedures, which found that while most of the patients claimed to be satisfied and experiencing no regret, there was little change in their psychological functioning. McHugh concluded that Johns Hopkins was, therefore, wasting scientific and technical resources by cooperating with a mental illness rather than trying to study, cure, and prevent it.<sup>33</sup> The clinic was shut down in

- 23 “Ex Gi Becomes Blonde Beauty.” Newspapers by Ancestry, <https://www.newspapers.com/article/daily-news-ex-gi-becomes-blonde-beauty/25375703/>.
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- 27 Schaefer, L. C., & Wheeler, C. C. “Harry Benjamin’s First Ten Cases (1938–1953): A Clinical Historical Note.” *Archives of Sexual Behavior* 24, no. 1 (1995/02/01 1995): 73-93. <https://doi.org/10.1007/BF01541990>.
- 28 Newspapers by Ancestry, <https://www.newspapers.com/article/altoona-tribune/3750641/>.
- 29 “Trans Medical Care at the Office of Dr. Harry Benjamin.” NYC LGBT Historic Sites Project, 2023, <https://www.nyclgbtsites.org/site/trans-medical-care-at-the-office-of-dr-harry-benjamin/>.
- 30 “Reed Erickson and the Erickson Educational Foundation.” University of Victoria, <https://www.uvic.ca/transgenderarchives/collections/reed-erickson/index.php>.
- 31 *Ibid* (n.30)
- 32 Diamond, M., & Sigmundson, H. K. “Sex Reassignment at Birth: Long-Term Review and Clinical Implications.” *Archives of Pediatrics & Adolescent Medicine* 151, no. 3 (1997): 298-304. <https://doi.org/10.1001/archpedi.1997.02170400084015>.
- 33 “Surgical Sex.” *First Things*, 2004, <https://www.firstthings.com/article/2004/11/surgical-sex?s=04&fbclid=IwAR2ULI9vuPZZQAJVMDFQub4PZ9S78mVMtDf6ssJ0Hdl8qRnuJS0myHEVbzA>.

1979.

Even Erickson's own story has no happily ever after, lending weight to McHugh's conclusions. After commencing hormonal and surgical sex change interventions under the care of Benjamin, Erickson developed a drug addiction and endured a lifelong battle with substance abuse. What followed was four failed marriages and a life of turmoil. Erickson's EEF folded in 1977, and the Harry Benjamin International Gender Dysphoria Association (HBIGDA) was formed in 1978, which would later become WPATH.

HBIGDA published its first Standards of Care (SOC) in 1979, followed closely by SOC2 in 1980, SOC3 in 1981, and SOC4 in 1990.<sup>34</sup> In its early days, HBIGDA members at least attempted to pursue science and an understanding of this complex psychiatric disorder and the various psychological, hormonal, and surgical interventions available as a form of treatment. But around the late 1990s, the group took a turn.

Dr. Stephen B. Levine was the chair of the SOC5 committee in 1998 and recommended that the guidelines require patients to obtain two letters from mental health professionals before commencing hormones.<sup>35</sup> Dr. Richard Green, HBIGDA president at the time, was unhappy with this requirement and so immediately commissioned SOC6, which was published just three years later and was almost identical but advised only one letter from a mental health professional.<sup>36</sup>

In the intervening years, activists began to overtake HBIGDA, and in 2002, Dr. Levine resigned his membership due to his "regretful conclusion that the

organization and its recommendations had become dominated by politics and ideology, rather than by scientific process, as it was years earlier."<sup>37</sup> In 2007, the organization changed its name to the World Professional Association for Transgender Health. This change was significant. At the stroke of a brush, a loose affiliation of people had appointed themselves as the leading international authority on gender medicine.

With the publication of its SOC7 in 2012, the ideological shift identified by Levine was evident. SOC7 recommended puberty blockers as a fully reversible pause for adolescents despite the fact that the experiment was still in its earliest stages and no such conclusion could be drawn. Also, while on the one hand, SOC7 encouraged caution and psychotherapy that affirms the transgender identity, on the other, the guidance endorsed the "informed consent model of care,"<sup>38</sup> which omits the need for psychotherapy and enables healthcare professionals to provide hormones on demand.<sup>39</sup> This came two years after WPATH had issued a statement calling for the "de-psychopathologization of gender variance worldwide," which framed being transgender as a normal, healthy variation of human existence.<sup>40</sup> SOC7 followed on from this, suggesting that any mental health issue in a person identifying as transgender is due to "minority stress," a result of prejudice and discrimination in society.<sup>41</sup>

Then, a year after the publication of SOC7, in line with WPATH, the American Psychiatric Association (APA) released the 5th edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-5), in which "gender identity disorder" was renamed "gender

34 "History and Purpose." WPATH, <https://www.wpath.org/soc8/history>.

35 Levine, S., Brown, G., Coleman, E., Cohen-Kettenis, P., Joris Hage, J., Maasdam, J., Petersen, M., Pfäfflin, F., & Schaefer, L. "The Hbigda Standards of Care for Gender Identity Disorders." *Journal of Psychology & Human Sexuality* 11 (12/06 1999). [https://doi.org/10.1300/J056v11n02\\_01](https://doi.org/10.1300/J056v11n02_01).

36 O'Malley, S. & Ayad, S. *Pioneers Series: We Contain Multitudes with Stephen Levine*. Podcast audio. *Gender: A Wider Lens Podcast* 2022. <https://gender-a-wider-lens.captivate.fm/episode/60-pioneers-series-we-contain-multitudes-with-stephen-levine>, 40:00.

37 "Dekker V Weida, Et. Al." 34-35. [https://ahca.myflorida.com/content/download/21427/file/Dekker\\_v\\_Weida\\_Levine\\_Report.pdf](https://ahca.myflorida.com/content/download/21427/file/Dekker_v_Weida_Levine_Report.pdf).

38 "Standards of Care-7th Version." WPATH, 35. [https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7\\_English.pdf](https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf).

39 Reisner, S. L., Bradford, J., Hopwood, R., Gonzalez, A., Makadon, H., Todisco, D., Cavanaugh, T., et al. "Comprehensive Transgender Healthcare: The Gender Affirming Clinical and Public Health Model of Fenway Health." *Journal of Urban Health* 92, no. 3 (2015): 584-92. <https://doi.org/10.1007/s11524-015-9947-2>.

40 "Wpath / Uspath Public Statements." WPATH, 2023, <https://www.wpath.org/policies>.

41 *Ibid* (n.38 p.4)

dysphoria.” This redefinition shifted the focus of diagnosis from the identity itself to the distress and difficulty in social functioning arising from the incongruity between the mind and body.

In the decade that passed between the publication of SOC7 and SOC8 in 2022, WPATH veered into new terrain. Just two days after SOC8 was published in September 2022, the group hastily removed almost all lower age requirements from the document,<sup>42</sup> in a bid to avoid malpractice lawsuits.<sup>43</sup> SOC8 also contains a chapter on nonbinary medical interventions, which include recommendations on nullification procedures to create a smooth, sexless appearance for people who identify as neither male nor female and penis-preserving vaginoplasties for those patients who desire both sets of genitals.

Of note, an earlier draft of SOC8 had contained a chapter on ethics, but this was cut from the final version. However, it was the inclusion of a whole chapter on eunuch as a valid gender identity, eligible for hormonal and surgical castration, that sent shockwaves through the medical profession and provided the catalyst for the

Beyond WPATH declaration, now signed by more than 2,000 concerned individuals, many of whom are clinicians working with gender diverse young people.<sup>44</sup> The declaration states that WPATH has discredited itself with its SOC8 and can no longer be viewed as a trustworthy source of clinical guidance in the field of gender medicine.

At Environmental Progress, we echo this call and go one step further, calling for reputable medical organizations like the American Academy of Pediatrics (AAP), the American Psychiatric Association (APA), and the American Medical Association (AMA) to cut ties with the organization and to abandon its guidelines in favor of ethical, evidence-based medicine.

The author of this report contacted each member who appears in the files and a leaked panel discussion requesting comment. However, despite these efforts, only one member of WPATH responded, and that response contained legal threats. Also, a source or sources shared an internal email showing WPATH advising against replying and informing the recipients that WPATH was seeking legal counsel.

42 “Wpath Explained.” Genspect, 2022, <https://genspect.org/wpath-explained/>.

43 “Wpath Explains Why They Removed Minimum Age Guidelines for Children to Access Transgender Medical Treatments: So Doctors Won’t Get Sued.” The Daily Wire, 2022, <https://www.dailywire.com/news/wpath-explains-why-they-removed-minimum-age-guidelines-for-children-to-access-transgender-medical-treatments-so-doctors-wont-get-sued>.

44 “Beyond Wpath.” Beyond WPATH, 2022, <https://beyondwpath.org/>.

## WPATH HAS MISLED THE PUBLIC

WPATH advocates for minors to have access to gender-affirming care, which is the treatment pathway involving puberty blockers, cross-sex hormones, and surgeries that are intended to align the young person's body with their self-declared transgender identity. Implicit in this endorsement is the fact that adolescents can sufficiently comprehend the full implications of these treatments, and their parents can provide legal informed consent.

The organization at the forefront of transgender health care claims that clinical guidelines for youth with self-declared transgender identities “support the use of interventions for appropriately assessed minors.”<sup>45</sup>

WPATH advises healthcare providers to use the World Health Organization's International Classification of Diseases (ICD-11) classification of “gender incongruence” over the DSM-5's “gender dysphoria.” This recommendation is motivated by the fact that the ICD-11 diagnosis is categorized as a “condition related to sexual health” and not a mental disorder, a move intended to destigmatize transgender identities further.

A diagnosis of gender incongruence is even easier to obtain than one of gender dysphoria because all the patient needs to experience is a marked incongruence between their internal sense of self and their biological sex. There is no requirement for the presence of distress as a criterion, meaning a patient's “embodiment goals” can be deemed medically necessary care.

But while WPATH publicly supports minors and their families consenting to these hormonal and surgical treatments based on a nebulous inner sense of self, privately, some members admit that consent is not possible. Behind closed doors, WPATH-affiliated healthcare professionals confess that their practices are based on

improvisation, that children cannot comprehend them, and that the consent process is not ethical. Thus, WPATH is dishonest with the public and knowingly operates without transparency.

### WPATH Knows Children Do Not Understand the Effects of Hormone Therapy

WPATH's Standards of Care 8 recommends adolescents who have received a diagnosis of “gender incongruence” have access to puberty blockers, cross-sex hormones, and surgeries so long as the young person “demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.”

However, in video footage obtained by Environmental Progress of an internal WPATH panel titled Identity Evolution Workshop held on May 6, 2022, panel members admit to the impossibility of getting proper informed consent for hormonal interventions from their young patients.<sup>46</sup>

During the panel, Dr. Daniel Metzger, a Canadian endocrinologist, discussed the challenges faced when attempting to obtain consent from adolescents seeking this medical treatment. Metzger reminded those assembled that gender doctors are “often explaining these sorts of things to people who haven't even had biology in high school yet,” adding that even adult patients often have very little medical understanding of the effects of these interventions.

Metzger describes young patients attempting to pick and choose the physical effects of hormone therapy, with some wanting a deeper voice without facial hair or to take estrogen without developing breasts. This suggests a very poor understanding of the workings of the human body and the treatment pathway on the part of adolescent

45 Leibowitz, S., Green, J., Massey, R., Boleware, A. M., Ehrensaft, D., Francis, W., Keo-Meier, C., et al. “Statement in Response to Calls for Banning Evidence-Based Supportive Health Interventions for Transgender and Gender Diverse Youth.” *International Journal of Transgender Health* 21, no. 1 (2020/01/02 2020): 111-12. <https://doi.org/10.1080/15532739.2020.1703652>. <https://shorturl.at/bDGUZ>

46 Massey, R., Berg, D., Ferrando, C., Green, J., & Metzger, D. (2022, May 6th) WPATH GEI Identity Evolution Workshop [internal panel].



patients, something noted by the WPATH expert.

“It’s hard to kind of pick and choose the effects that you want,” concluded Metzger. “That’s something that kids wouldn’t normally understand because they haven’t had biology yet, but I think a lot of adults as well are hoping to be able to get X without getting Y, and that’s not always possible.”

Metzger tells his young patients that they might not “be binary, but hormones are binary.” He describes having to explain to children and even adults that “you can’t get a deeper voice without probably a bit of a beard” and “you can’t get estrogen to feel more feminine without some breast development.”

There was agreement among the panel of experts about children’s inability to comprehend the powerful and life-altering effects of the hormone therapy they are seeking. Another prominent WPATH member, Dianne Berg, a child psychologist and co-author of the child chapter of SOC8, chimed in to say that they wouldn’t expect children and young adolescents to grasp the effects of the treatment because it is “out of their developmental range to understand the extent to which some of these medical interventions are impacting them.”

The immaturity of these patients was further demonstrated when Berg said, “They’ll say they understand, but then they’ll say something else that makes you think, oh, they didn’t really understand that they are going to have facial hair.”

Yet, publicly, WPATH never discusses any of this. On the rare occasion that WPATH makes public statements, sex-trait modification interventions are presented as age-appropriate, essential medical care, and any opposition to such interventions is framed as transphobia.

“Anti-transgender health care legislation is not about protections for children but about eliminating transgender persons on a micro and macro scale,” said WPATH President Dr. Marci Bowers in a May 2023 statement

opposing US bans on gender-affirming care for minors. “It is a thinly veiled attempt to enforce the notion of a gender binary.”<sup>47</sup>

It is the responsibility of parents to provide legal consent before a doctor can block a child’s puberty or administer irreversible cross-sex hormones, but during the panel, Berg provides evidence that even some parents do not have sufficient levels of health literacy to comprehend the effects of this treatment protocol, and she admits that current practices are not ethical.

“What really disturbs me is when the parents can’t tell me what they need to know about a medical intervention that apparently they signed off for,” said Berg. She suggests a solution is to “normalize” that it is okay not to understand right away and to encourage patients to ask questions. That way, gender-affirming healthcare providers can do a “real informed consent process” rather than what is currently happening, which Berg thinks is “not what we need to be doing ethically.”

### WPATH Knows Children Cannot Consent to Iatrogenic Fertility Loss

Another crucial aspect of the informed consent process that these WPATH members confess is being violated is the issue of allowing minors to consent to a treatment pathway that could result in sterility. WPATH’s SOC8 stipulates that doctors must inform the young person about “the potential loss of fertility and available options to preserve fertility.” By advocating for adolescents in early puberty to have access to hormonal interventions that could leave them sterile, the world-leading transgender health group is implying that minors have the cognitive capacity to make such a decision about their future.

However, on the inside, prominent WPATH members confess that it is impossible for adolescents to understand the gravity of the decision. Dr. Ren Massey, a psychologist and co-author of the adolescent chapter of the latest

47 “Statement of Opposition to Legislation Banning Access to Gender-Affirming Health Care in the Us.” WPATH, 2023, [https://www.wpath.org/media/cms/Documents/Public%20Policies/2023/USPATH\\_WPATH%20Statement%20re\\_%20GAHC%20march%208%202023.pdf](https://www.wpath.org/media/cms/Documents/Public%20Policies/2023/USPATH_WPATH%20Statement%20re_%20GAHC%20march%208%202023.pdf).

standards of care, told the panel that, according to SOC8, “it’s encouraged, and ethical, to talk about fertility preservation options,” stressing that it is “even important for youth who are going on puberty blockers because many of those youth will go directly onto affirming hormone therapies which will eliminate the development of their gonads producing sperm or eggs,” a function that the young patients may desire “if they want to be partners with somebody else later in contributing genetic material for reproduction.”

Metzger responded that “it’s always a good theory that you talk about fertility preservation with a 14-year-old, but I know I’m talking to a blank wall,” adding, “they’d be like, ew, kids, babies, gross.”

“Or, the usual answer is, ‘I’m just going to adopt.’ And then you ask them, well, what does that involve? Like, how much does it cost? ‘Oh, I thought you just like went to the orphanage, and they gave you a baby.’”

This remark was met with smiles and nods from the panel. These comments prove that WPATH members are aware that the young patients who will lose their fertility as a consequence of gender-affirming treatments don’t yet understand what they are sacrificing. They do not understand how they may come to want biological children of their own one day, nor do they even understand how adoption works or how arduous it can be to conceive a baby via in vitro fertilization.

These private comments are in stark contrast to WPATH’s public stance. In a recent statement opposing US bans on sex-trait modification interventions for minors, WPATH said, “the benefits that these medically necessary interventions have for the overwhelming majority of youth ... are well-documented. Providers who collaboratively assess youths’ understanding of themselves, their gender identity, and their ability to make informed decisions regarding medical/surgical interventions (which are not offered prior to puberty and never without the youth’s

assent) play a very important role in minimizing future regret.” However, WPATH members know this level of understanding is simply not possible, making WPATH’s statement dishonest.

What’s more, members are aware that there is already research showing significant reproductive regret among a cohort of Dutch patients who were some of the first to undergo early puberty suppression.

Metzger told the panel about data presented by Dutch researchers at a recent meeting of the Pediatric Endocrine Society. “Some of the Dutch researchers gave some data about young adults who had transitioned and [had] reproductive regret, like regret, and it’s there,” he said, “and I don’t think any of that surprises us.”

One reason Metzger is not surprised is that he has observed regret in his own patients.

“I think now that I follow a lot of kids into their mid-twenties, I’m like, ‘Oh, the dog isn’t doing it for you, is it?’ They’re like, ‘No, I just found this wonderful partner, and now want kids’ and da da da. So I think, you know, it doesn’t surprise me,” said Metzger.

In fact, the preliminary findings of the research to which Metzger appears to be referring were presented a few months later at WPATH’s International Symposium in Montreal in September 2022.<sup>48</sup> The team of Dutch researchers gave a presentation of the results of the first long-term study of young people who had their puberty suppressed, and as Metzger suggested, the results were far from encouraging.

In a segment titled, *Reflecting on the Importance of Family Building and Fertility Preservation*, Dr. Joyce Asseler revealed that 27% of the young people who had undergone early puberty suppression followed by cross-sex hormones and surgical removal of the testes or ovaries, now, at an average age of 32, regret sacrificing their fertility, or as the Dutch researchers worded it, “find their infertility troublesome.” A further 11% are unsure about

48 Steensma, T. D., de Rooy, F. B. B., van der Meulen, I. S., Asseler, J. D., & van der Miesen, A. I. R. (2022, September 16–20). *Transgender Care Over the Years: First Long-Term Follow-Up Studies and Exploration of Sex Ratio in the Amsterdam Child and Adolescent Gender Clinic* [Conference presentation].



how they feel about their infertility, and while none opted for fertility preservation in the form of freezing their eggs or sperm before embarking upon medical transition as adolescents, 44% of the natal females and 35% of the natal males would now choose fertility preservation if they could go back in time. The majority, 56%, of study participants either have the desire for children or have already “fulfilled this desire,” presumably by adoption.

The 27% regret rate is also very likely an underestimate. Asseler quotes one participant who did not find their infertility “troublesome,” who responded, “I can find it troublesome, but it’s too little too late. Unfortunately, I can’t change it, even if I would like to.” Also, like most other studies in this field, this one suffers from a high loss to follow-up, with 50.7% of eligible participants failing to take part, so we cannot know the true regret rate in this cohort of young people.

Berg remarked that the issue of 9-year-olds grappling with understanding lifelong sterility has her “stumped,” and Metzger acknowledged that “most of the kids are nowhere in any kind of a brain space to really talk about it in a serious way.” This bothers the WPATH expert, who just wants “kids to be happy, happier, in the moment.”

While prioritizing the alleviation of a child’s distress in the present moment at the cost of their future fertility is deeply misguided, Metzger makes further comments indicating that WPATH’s gender-affirming care doesn’t even accomplish this dubious goal. Metzger says putting a nine-year-old on puberty blockers before they get to the age of developing their sexual identity “cannot be great,” and admits that gender-affirming doctors are “to a degree robbing these kids of that sort of early-to-mid pubertal sexual stuff that’s happening with their cisgender peers.”

Adolescence is a difficult time for any young person as they yearn for acceptance among their peers. Erik Erikson, a child psychoanalyst, stated that the primary goal of adolescence is to establish identity.<sup>49</sup> He viewed adolescence

as a time of confusion and experimentation. Building on Erikson’s work, Canadian developmental psychologist James Marcia coined the term “identity moratorium,” describing the stage of adolescence as an exploration rather than a time for a young person to commit to any single cause or identity.<sup>50</sup>

Identity development during this crucial phase relies heavily on social interactions, and the experience of isolation and loneliness is especially distressing for a young person still finding their way in the world. Therefore, Metzger’s comments show that WPATH is knowingly promoting a medical treatment that might exacerbate an adolescent’s social challenges rather than alleviate them, meaning this medical intervention, which comes at such an enormous cost, fails even to achieve Metzger’s misguided aim of making kids “happier in the moment.”

What’s more, a thread in WPATH’s internal messaging forum provides proof that some adolescents with developmental delays are being put on puberty blockers. A physician-assistant and professor at Yale School of Medicine posted in the group asking for advice about a developmentally delayed 13-year-old who was already on puberty blockers but may not reach the “emotional and cognitive developmental bar set by [SOC8] within the typical adolescent time frame if at all” to give cognitive consent to cross-sex hormones. The Yale professor and practicing clinician wanted to know when it would be ethical to allow the young patient to progress to “gender-affirming hormone therapy.”

A psychiatrist from Nova Scotia replied that the “guiding principle would be weighing [the] harm of acting vs not acting.” This WPATH member defined “harm” as halting puberty suppression and advised that puberty blockers cannot be continued indefinitely without a sex steroid hormone as well. A Pennsylvania therapist replied saying, “[k]ids with intellectual disabilities are able to consent to other surgeries,” and wondered if there was

49 Erikson, E. H. (1968). *Identity: youth and crisis*. Norton & Co.

50 Kroger, J., & Marcia, J. (2011). The Identity Stages: Origins, Meanings, and Interpretations. In (pp. 31-53). [https://doi.org/10.1007/978-1-4419-7988-9\\_2](https://doi.org/10.1007/978-1-4419-7988-9_2)

important context missing from the original post.

An activist and law professor at the University of Alberta shared a paper to help the Yale professor solve this ethical conundrum. “Regardless of patients’ capacity, there is usually nobody better positioned to make medical decisions that go to the heart of a patient’s identity than the patients themselves,” says the paper, adding that because “gender uniquely pertains to personal identity and self-realisation, parents...are rarely better positioned to make complex medical decisions.”<sup>51</sup>

Because parents are usually “cisgender,” meaning not transgender, they “rarely have an intimate appreciation of transness or gender dysphoria, and never have an intimate appreciation of the patient’s gender subjectivity,” reads the paper. By contrast, patients, even developmentally delayed adolescents, have an “intimate understanding of their own gender subjectivity” and will almost always have a “substantial, although limited, appreciation” of the risk of harm and infertility.

Therefore, according to this logic, minors who identify as transgender, even those with severe mental health issues or developmental delays, can “appreciate both sides of the equation,” meaning they are better positioned than their parents to make complex medical decisions that will have life-long consequences.

This political activist, who has no medical training, is a frequent contributor to the conversations inside the WPATH forum. However, this opinion is, in fact, in line with WPATH’s official stance on allowing adolescents with developmental delays to give cognitive consent to experimental sex-trait modification interventions. In a 2022 public statement, WPATH called delaying or withholding puberty blockers and cross-sex hormones from

adolescents with coexisting autism, other developmental differences, or mental health problems “inequitable, discriminatory, and misguided.”<sup>52</sup>

Robbing adolescents of their developing sexual identities poses another problem for the panel of WPATH experts. As Metzger notes, this cohort’s sexual urges are suppressed, meaning they are not “learning how to masturbate.” However, these same healthcare providers are tasked with discussing fertility preservation options with their patients who are not developmentally equipped to understand the process. In the case of natal males, the freezing of sperm requires that the adolescent has reached this crucial developmental stage. Especially for boys, the logic of early intervention dictates that puberty be suppressed as soon as possible, meaning before endogenous hormones have had a chance to make the body fertile.

Berg is aware of this problem, telling the group, “In some ways, the stuff that you need to do to be able to preserve your fertility might be beyond where a youth is at in terms of their sexual development, and yet, that’s kind of what’s needing to happen.”

In traditional pediatrics, this type of conversation would only occur in oncology. Fertility preservation is offered to children with certain disorders of sexual development (DSDs) and other rare health conditions,<sup>53</sup> but it is only cancer treatment and gender-affirming medicine that cause iatrogenic infertility, meaning it is the treatment protocol that destroys the young person’s fertility. Prior to the advent of gender-affirming care, the only justifiable reason for sterilizing a minor was a potentially life-threatening cancer diagnosis.

In a WPATH public statement from 2020, which was co-authored by two of the Identity Evolution Workshop

51 Ashley, F. (2023). Youth should decide: the principle of subsidiarity in paediatric transgender healthcare. *J Med Ethics*, 49(2), 110-114. <https://doi.org/10.1136/medethics-2021-107820> <https://pubmed.ncbi.nlm.nih.gov/35131805/>

52 WPATH, ASIAPATH, EPATH, PATHA, and USPATH Response to NHS England in the United Kingdom (UK). (2022). <https://www.wpath.org/media/cms/Documents/Public%20Policies/2022/25.11.22%20AUSPATH%20Statement%20reworked%20for%20WPATH%20Final%20ASIAPATH.EPATH.PATHA.USPATH.pdf?t=1669428978>

53 Rodriguez-Wallberg, K. A., Marklund, A., Lundberg, F., Wikander, I., Milenkovic, M., Anastacio, A., Sergouniotis, F., Wånggren, K., Ekengren, J., Lind, T., & Borgström, B. (2019). A prospective study of women and girls undergoing fertility preservation due to oncologic and non-oncologic indications in Sweden-Trends in patients’ choices and benefit of the chosen methods after long-term follow up. *Acta Obstet Gynecol Scand*, 98(5), 604-615. <https://doi.org/10.1111/aogs.13559>

panelists, the leading transgender health group claims that “in general, mental health and medical professionals conduct evaluations of each youth/family to ensure that interventions used to promote emotional and psychological wellness in these youth are appropriate and meet the young person’s specific mental health and medical needs.”<sup>54</sup>

“As a result, professionals with experience and training to understand adolescent development and family dynamics are poised to understand the underlying factors behind a specific clinical presentation,” said WPATH. “The best interests of the child are always paramount for any responsible licensed provider.”

Compare that to what WPATH members say when they think the public is not listening. Jamison Green, a trans rights activist, former WPATH president, and one of the co-authors of the statement, told the panel that many patients may never even see an endocrinologist and are instead getting their “hormones prescribed through their primary care provider who doesn’t really know necessarily everything about trans care.”

Green believes these primary care providers are just “trying to be supportive” but explains that because the field of gender medicine is “new” and “contentious,” patients, even well-educated adults who are accessing care for the first time, will hastily glance at the informed consent form, not take any of the information in, and say, “show me where to sign. Cause this is my moment, I gotta grab it.”

This comment is in complete contradiction to WPATH’s official statement claiming that a team of medical and mental health professionals carefully evaluates young patients. And this doesn’t just happen with access to hormones. Green makes the same remarks regarding patients consenting to life-altering surgeries.

“People also are afraid many times about surgery, and so they can read other people’s descriptions about surgery, and they’ll miss details, or they’ll miss the most important piece of information for them simply because they’re afraid to read it,” explained Green.

54 Ibid (n.45)

## WPATH IS NOT A SCIENTIFIC GROUP

WPATH presents itself to the world as a scientific organization. The group describes its “Standards of Care” as being “based on the best available science and expert professional consensus.”

In a 2022 speech in Texas, the US Assistant Secretary for Health, Admiral Rachel Levine said that WPATH’s approach to medicine is “free of any agenda other than to ensure that medical decisions are informed by science.”<sup>55</sup> In an op-ed in the New York Times from April, 2023, WPATH President Bowers argued that the “field of transgender medicine is evolving rapidly, but it is every bit as objective- and outcome-driven as any other specialty in medicine.”<sup>56</sup>

“Allow the remaining scientific questions to be answered by knowledgeable researchers, without the influence of politics and ideology,” Bowers implored.

However, the scientific method is a systematic approach to establishing facts through rigorous testing and experimentation. In the realm of medical research, this process entails observing a medical condition requiring intervention and formulating a hypothesis regarding a potentially effective treatment. This hypothesis is then put to the test through rigorously controlled trials, preferably ones that are both randomized and double-blind, meaning the participants are randomly assigned to different groups, and neither the participants nor the researchers know which group is receiving the treatment and which is receiving a placebo or alternative intervention. The final crucial step in the process is a follow-up, meaning all participants must be monitored over a sufficient duration and the results carefully analyzed to gauge the treatment’s

efficacy and safety.

The WPATH Files contain abundant evidence that the world-leading transgender health group does not respect the well-established scientific process.

Even the term “standards of care” is a misnomer when applied to WPATH’s SOC7 and SOC8. “Standard of care” is a legal term, not a medical term, and represents “the benchmark that determines whether professional obligations to patients have been met.”<sup>57</sup> Failure to meet the standard of care is medical negligence, which can result in significant consequences for healthcare providers.

However, from WPATH’s SOC7 onwards, there are no “standards.” A 2021 systematic review of clinical guidelines in gender medicine did not merely rate SOC7 as low quality but also rated it as “do not recommend.”<sup>58</sup> The review concluded with the hope that the upcoming SOC8 would improve on SOC7’s numerous shortcomings, but instead, SOC8 strayed even further from meeting the definition of a standard of care.

WPATH’s SOC8 gives gender-affirming healthcare providers permission to do whatever the patient requests, in the absence of scientific evidence, safe in the knowledge that insurance companies will offer coverage because every intervention is defined as “medically necessary.” Simultaneously, these providers believe themselves to be protected from malpractice lawsuits because they adhere to these approved “standards of care” that, in truth, contain no actual “standards” since all criteria are optional.

### The Weak Evidence Base for Puberty Suppression

Nowhere is WPATH’s disregard for the scientific

55 Levine, R. (2022). Remarks by HHS Assistant Secretary for Health ADM Rachel Levine for the 2022 Out For Health Conference. U.S. Department of Health and Human Services. <https://www.hhs.gov/about/news/2022/04/30/remarks-by-hhs-assistant-secretary-for-health-adm-rachel-levine-for-the-2022-out-for-health-conference.html>

56 “What Decades of Providing Trans Health Care Have Taught Me.” The New York Times, 2023, <https://www.nytimes.com/2023/04/01/opinion/trans-healthcare-law.html>.

57 Vanderpool, D. (2021). The Standard of Care. *Innov Clin Neurosci*, 18(7-9), 50-51. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8667701/#:~:text=The%20standard%20of%20care%20is%20a%20legal%20term%2C%20not%20a,legal%20standard%20varies%20by%20state.>

58 Dahlen, S., Connolly, D., Arif, I., Junejo, M. H., Bewley, S., & Meads, C. (2021). International clinical practice guidelines for gender minority/trans people: systematic review and quality assessment. *BMJ Open*, 11(4), e048943. <https://doi.org/10.1136/bmjopen-2021-048943>

process more evident than in its support for adolescent sex-trait modification involving puberty blockers, cross-sex hormones, and surgeries for minors suffering from gender dysphoria. The world's most prominent transgender healthcare group endorses this controversial treatment protocol, and the WPATH Files contain abundant evidence demonstrating just how little is known about the drugs and their long-term effects.

In the 2023 paper, *The Myth of Reliable Research*,<sup>59</sup> Abbruzzese et al. argue that the practice of performing sex-trait modifications on minors through the use of puberty blockers, cross-sex hormones, and surgeries is an experiment that “escaped the lab” before there was any strong scientific evidence to support it.

Rather than being “evidence-based” as WPATH claims, Abbruzzese et al. explain that pediatric sex-trait modification was an “innovative practice” embarked upon by researchers in a Dutch clinic in the late 1980s-early 1990s. The “innovative practice” framework allows clinicians to implement untested yet encouraging interventions in cases where leaving the condition untreated could have dire consequences, when established treatments appear ineffective, and when the patient population is small.

Innovative practice is a double-edged sword because while it has the potential to advance medicine rapidly, it is also capable of causing harm. Hence, it is an ethical requirement to follow innovative experiments with strict clinical trials to demonstrate that the treatment's advantages outweigh the associated risks.

The clinical trial stage is imperative to avoid a

phenomenon called runaway diffusion, “whereby the medical community mistakes a small innovative experiment as a proven practice, and a potentially non-beneficial or harmful practice ‘escapes the lab,’ rapidly spreading into general clinical settings.”<sup>60</sup>

Runaway diffusion is what happened with pediatric gender medicine. Based on a study group of just 55 participants, which suffered from high selection bias, and a study design so methodologically flawed that its results should have been completely invalidated, the international medical community began suppressing the puberty of adolescents suffering from gender dysphoria. The vital step of undertaking controlled research aimed at validating the hypothesized substantial and enduring psychological advantages was completely skipped.

In fact, as early as 2001, WPATH, then HBIGDA, endorsed the treatment in its Standards of Care 6, even though, at that time, the scientific evidence for the protocol consisted of just a single case study involving one young patient.<sup>61,62,63</sup> Then, before the second stage of the deeply flawed Dutch experiment had been completed, WPATH again endorsed the treatment in its Standards of Care 7 in 2012, thereby influencing the medical community and leading to the widespread adoption of the protocol.<sup>64</sup>

The speed of the runaway diffusion increased dramatically when the innovative medical experiment collided with the sudden surge of adolescents identifying as transgender in the mid-2010s.

While *The Myth of Reliable Research* specifically criticizes the adolescent sex-trait modification experiment, there have never been any properly controlled trials in the

59 Abbruzzese, E., Levine, S. B., & Mason, J. W. “The Myth of “Reliable Research” in Pediatric Gender Medicine: A Critical Evaluation of the Dutch Studies—and Research That Has Followed.” *Journal of Sex & Marital Therapy* 49, no. 6 (2023): 673-99. <https://doi.org/10.1080/0092623x.2022.2150346>.

60 Ibid (n.59)

61 Biggs, M. “The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence.” *Journal of Sex & Marital Therapy* 49, no. 4 (2023): 348-68. <https://doi.org/10.1080/0092623x.2022.2121238>.

62 Meyer III, W., Bockting, W.O., Cohen-Kettenis, P., Coleman, E., DiCeglie, D., Devor, H., Gooren, L., et al. “The Harry Benjamin International Gender Dysphoria Association’s Standards of Care for Gender Identity Disorders, Sixth Version.” *Journal of Psychology & Human Sexuality* 13, no. 1 (2002): 1-30. <https://www.cpath.ca/wp-content/uploads/2009/12/WPATHsocv6.pdf>.

63 Cohen-Kettenis, P. T., & van Goozen, S. H. “Pubertal Delay as an Aid in Diagnosis and Treatment of a Transsexual Adolescent.” [In eng]. *Eur Child Adolesc Psychiatry* 7, no. 4 (Dec 1998): 246-8. <https://doi.org/10.1007/s007870050073>.

64 Ibid (n.38 p.18)

wider field of gender medicine, which also consistently lacks long-term data. Studies that show a positive outcome for sex-trait modification procedures have a very short follow-up period, and those that attempt to monitor how patients fare years after undergoing hormonal and surgical interventions are compromised by a high percentage of study participants lost to follow-up. The few attempts at long-term follow-up for adults who have undergone sex-trait modification interventions do not show positive outcomes, with individuals showing social difficulties and a significantly elevated rate of completed suicides and mental health issues.<sup>65,66,67,68</sup> While each of these studies has its methodological limitations, the findings cast serious doubt on any claims that sex-trait modification interventions result in overwhelmingly positive outcomes for patients. Not surprisingly, systematic reviews of the research on sex trait modification in minors have consistently found “low” or “very low” quality evidence for benefits.

### Evidence in the Files of WPATH’s Lack of Respect for the Scientific Process

A discussion in the WPATH Files involving WPATH’s president, Dr. Marci Bowers, demonstrates the pseudoscientific, experimental nature of pediatric hormonal and surgical sex-trait modification. Bowers makes it abundantly clear that there is no scientific rigor to the treatment protocol when discussing how little is known about the impact puberty blockers have on the future sexual function of natal males.

In January 2022, WPATH President Bowers admitted in the forum that the effect of puberty blockers on fertility and “the onset of orgasmic response” is not yet fully understood. Also, Bowers conceded that there are “problematic surgical outcomes” for natal males who have

their puberty blocked early.

In fact, almost everything Bowers contributed to the discussion board about fertility, puberty blockers, and sexual intimacy is proof that the leading transgender health group advocates for an unregulated experiment on young people.

Bowers told the group that the “fertility question has no research” and recommended that “Unless pre-pubertal dysphoria is enormous, allowing for a small amount of puberty before blockers might be preferable in the long run.”

In this context, the use of the word “might” suggests that these doctors are improvising, experimenting without a structured framework, and, because of inadequate follow-up, failing to track the outcome of their experiment. This type of guesswork is acceptable in a small experiment but unethical when every major American medical association recommends the treatment and the wider medical community has already adopted it.

Bowers then said the question of whether or not these young males will be able to achieve orgasm later in life was “thornier,” with the WPATH president admitting that all personal clinical experience up to that point indicated that boys who have their puberty blocked at Tanner Stage 2, the beginning of pubertal development, are completely unable to orgasm. “Clearly, this number needs documentation, and the long-term sexual health of these individuals needs to be tracked,” said Bowers.

In other words, Bowers is aware that gender-affirming healthcare providers are robbing young natal males of the ability to orgasm and, therefore, their future ability to form long-term intimate relationships, which is an essential part of a fulfilling and happy life for most people. What’s more, gender-affirming doctors are choosing this drastic medical

65 “Mistaken Identity.” *The Guardian*, 2004, <https://www.theguardian.com/society/2004/jul/31/health.socialcare>.

66 Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L. V., Långström, N., & Landén, M. “Long-Term Follow-up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden.” *PLoS ONE* 6, no. 2 (2011): e16885. <https://doi.org/10.1371/journal.pone.0016885>.

67 Kuhn, A., Bodmer, C., Stadlmayr, W., Kuhn, P., Mueller, M. D., & Birkhäuser, M. “Quality of Life 15 Years after Sex Reassignment Surgery for Transsexualism.” *Fertility and Sterility* 92, no. 5 (2009): 1685-89.e3. <https://doi.org/10.1016/j.fertnstert.2008.08.126>.

68 “Part 3: Gender Identity.” *Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences*, The New Atlantis, 2016, <https://www.thenewatlantis.com/publications/part-three-gender-identity-sexuality-and-gender>.



intervention as the first line of treatment for this vulnerable cohort of young people while ignoring the scientific literature that shows most children would overcome their dysphoria if allowed to grow and develop naturally without medical intervention.<sup>69,70,71</sup> While this literature predates the newly emerged adolescent-onset cohort, all existing knowledge about adolescent identity development strongly supports allowing these young patients the chance to grow and mature before making drastic, life-altering decisions.<sup>72</sup>

If WPATH, as Bowers claimed in the *New York Times*, were every bit as objective- and outcome-driven as any other specialty in medicine, these questions would have been answered before the group recommended the treatment protocol be rolled out into wider medical practice.

Bowers also mentioned the “problematic surgical outcomes” faced by these patients. Here, the WPATH president is referring to the fact that natal males who have their puberty suppressed at Tanner Stage 2 typically require a more complicated vaginoplasty surgery than the standard penile inversion.

In a fully developed adult male, vaginoplasty involves inversion of the penis, using the penile skin to line the surgical cavity that is meant to resemble a vagina. But in natal males who have their puberty blocked, the penis remains in a child-like state, meaning there is insufficient penile tissue to use during the procedure. Therefore, the surgeon must harvest tissue from a different part of the body. The most common technique uses a piece of the patient’s colon, or less frequently, surgeons will use the

peritoneum lining, which is the lining of the abdominal cavity. Some gender surgeons are even experimenting with using tilapia fish skin.<sup>73</sup>

There are two notable examples of the “problematic surgical outcomes” that can ensue as a result of these riskier surgeries. The first is the tragic death of an 18-year-old natal male who participated in the pioneering Dutch trial and died of necrotizing fasciitis.<sup>74</sup> This devastating outcome resulted from surgeons opting to use a section of the teen’s intestines to construct the pseudo-vagina, a measure necessitated by the patient’s lack of male puberty. This one death represents an almost 2% fatality rate associated with surgery in the Dutch study. In any other field of medicine, such a high fatality rate would result in the experiment instantly being halted and carefully studied to investigate what went wrong.

Then there is the story of Jazz Jennings, the trans-identified natal male star of the reality TV show *I Am Jazz*. Jennings was also one of the first children to take part in the puberty suppression experiment, and when it came time for vaginoplasty, Jazz also had insufficient penile tissue, making it necessary to use part of Jazz’s peritoneum lining and a section of thigh skin. Bowers was the surgeon who performed the operation. Days after the surgery, the pseudo-vagina came apart, causing Jazz intense pain and requiring three corrective surgeries.

One study found that 71% of the natal males who had undergone puberty suppression at Tanner Stages 2-3 required the riskier form of intestinal vaginoplasty.<sup>75</sup> Another study found one-quarter of males who undergo

69 Ibid (n.2)

70 Ibid (n.4).

71 Wallien, M. S., & Cohen-Kettenis, P. T. “Psychosexual Outcome of Gender-Dysphoric Children.” [In eng]. *J Am Acad Child Adolesc Psychiatry* 47, no. 12 (Dec 2008): 1413-23. <https://doi.org/10.1097/CHI.0b013e31818956b9>.

72 Ibid (n.49); Ibid (n.50)

73 Slongo, H., Riccetto, C. L. Z., Junior, M. M., Brito, L. G. O., & Bezerra, L. “Tilapia Skin for Neovaginoplasty after Sex Reassignment Surgery.” [In eng]. *J Minim Invasive Gynecol* 27, no. 6 (Sep-Oct 2020): 1260. <https://doi.org/10.1016/j.jmig.2019.12.004>.

74 Negenborn, V. L., van der Sluis, W. B., Meijerink, W., & Bouman, M. B. “Lethal Necrotizing Cellulitis Caused by Esbl-Producing E. Coli after Laparoscopic Intestinal Vaginoplasty.” [In eng]. *J Pediatr Adolesc Gynecol* 30, no. 1 (Feb 2017): e19-e21. <https://doi.org/10.1016/j.jpag.2016.09.005>.

75 van der Sluis, W. B., de Nic, I., Steensma, T. D., van Mello, N. M., Lissenberg-Witte, B. I., & Bouman, M. B. “Surgical and Demographic Trends in Genital Gender-Affirming Surgery in Transgender Women: 40 Years of Experience in Amsterdam.” [In eng]. *Br J Surg* 109, no. 1 (Dec 17 2021): 8-11. <https://doi.org/10.1093/bjs/zna213>.

this type of vaginoplasty require follow-up corrective surgery.<sup>76</sup>

Further evidence of the uncertainty surrounding the puberty suppression experiment is present in the WPATH Files. In February 2022, a Seattle psychologist asked the forum for information about the impact puberty blockers have on a young person's height. The psychologist was confused after reading and hearing "some conflicting information." The patient who sparked the inquiry was a 10-year-old "premenarche" natal female who identified as a boy. The child was concerned that taking puberty blockers would stunt growth, so the psychologist asked the forum if starting the drugs so young could have a negative impact.

The reply from a pediatric endocrinologist demonstrates that the whole experiment is based on guesswork. She explains that blockers suppress puberty to keep growth plates open longer, so younger teens have more time to grow, but the typical adolescent growth spurt is also blocked. To remedy this, the endocrinologist says she gives a low dose of testosterone to these young teenage girls and gradually increases the dose, hoping that the growth plates don't close.

It's relevant at this point to note that the puberty suppression experiment began because transgender adult males were dissatisfied with the results of their medical transition because they did not "pass" well as women due to a "never disappearing masculine appearance."<sup>77</sup> Therefore, the Dutch researchers came up with the idea to use gonadotropin-releasing hormone agonists (GnRHa) to block the testosterone surge of male puberty in the hopes of achieving more feminine appearances in adulthood. The

increased risk of false positives due to early intervention was noted, but the cosmetic advantages to adult natal males who identify as women were deemed more important.<sup>78</sup>

In 2014, Delemarre-van de Waal reviewed the puberty suppression experiment, stating that "an early intervention in a male-to-female transsexual may result in a more acceptable female final height." The word height was mentioned no fewer than 23 times in the paper.<sup>79</sup> There was only one mention of loss of fertility. As one researcher later noted, the "words orgasm, libido, and sexuality do not appear" even once.<sup>80</sup>

However, the aforementioned exchange in the WPATH Files indicates that natal females may experience poorer outcomes from having their puberty blocked. Testosterone use typically brings about convincing cosmetic changes in females who identify as male, making height the biggest challenge trans-identified natal females face when trying to pass as men. Since natal females constitute the majority of referrals to pediatric gender clinics, if it is indeed true that these drugs negatively affect the height of female patients, it calls into question the validity of the original hypothesis for their use.

What's more, the superficial focus on "passing" as a member of the opposite sex ignores the reality of human sexuality. A transgender person who passes when out in public is still going to experience difficulty finding a romantic partner because of the limitations of sex-trait modification interventions. For those who do not opt for genital surgery, their outward appearance is incongruent with their genitals, and for those who do opt for full surgical transition, there are limitations of what such

- 76 Bouman, M. B., van der Sluis, W. B., Buncamper, M. E., Özer, M., Mullender, M. G., & Meijerink, W. "Primary Total Laparoscopic Sigmoid Vaginoplasty in Transgender Women with Penoscrotal Hypoplasia: A Prospective Cohort Study of Surgical Outcomes and Follow-up of 42 Patients." [In eng]. *Plast Reconstr Surg* 138, no. 4 (Oct 2016): 614e-23e. <https://doi.org/10.1097/prs.0000000000002549>.
- 77 Waal, H., & Cohen-Kettenis, P. "Clinical Management of Gender Identity Disorder in Adolescents: A Protocol on Psychological and Paediatric Endocrinology Aspects." *European Journal of Endocrinology - EURJ ENDOCRINOLOGY* 155 (10/30 2006). <https://doi.org/10.1530/ejc.1.02231>.
- 78 Ibid (n.77)
- 79 Delemarre-van de Waal, H. A. "Early Medical Intervention in Adolescents with Gender Dysphoria." In *Gender Dysphoria and Disorders of Sex Development: Progress in Care and Knowledge*, edited by Baudewijntje P. C. Kreukels, Thomas D. Steensma and Annelou L. C. de Vries, 193-203. Boston, MA: Springer US, 2014. [https://link.springer.com/chapter/10.1007/978-1-4614-7441-8\\_10#citeas](https://link.springer.com/chapter/10.1007/978-1-4614-7441-8_10#citeas)
- 80 Ibid (n.61)



surgeries can achieve. In either case, the ability to form long-term sexual relationships is drastically compromised.

If WPATH were indeed a scientific organization dedicated to ensuring that its members provide the best possible care for patients suffering from gender dysphoria, including minors and those with serious psychiatric comorbidities, it would fund proper clinical trials to assess

the safety, effectiveness, risks, and benefits of the treatment protocol for which it so strenuously advocates. An essential part of these trials would be long-term follow-up to measure the impact of allowing adolescents to compromise their health, fertility, and sexual function at such a young age.

## WPATH IS NOT A MEDICAL GROUP

### WPATH Has Abandoned the Hippocratic Oath

For over 2,500 years, physicians have been guided by the Hippocratic oath to first do no harm. While this exact adage is not present in the original text from 5th century BC Greece, the pledge is a distillation of the oath's overarching message to consider the benefit of patients and "abstain from whatever is deleterious and mischievous."

The phrase "First, do no harm," or its Latin translation, "Primum non nocere," is the bedrock upon which medical ethics standards are built, and it has provided a moral and ethical compass for physicians for thousands of years. While medicine and technology have advanced beyond recognition since the days of Hippocrates, the oath's guiding principle has always remained the same: the benefits of a medical treatment must always outweigh any harm.

Throughout the ages, medical professionals have sought to balance taking risks with patient safety, and still, to this day, that can be challenging, especially in high-stakes areas of medicine such as cancer treatment. In fact, it is appropriate to compare WPATH's gender-affirming care to cancer treatment because both protocols involve the use of powerful drugs that have a profound impact on future health and reproductive function, as well as, in many cases, the surgical removal of body parts.

But while most people would agree that doctors are justified in administering treatments such as chemotherapy that could result in sterility or amputating body parts if a child or young person has cancer and the surgery could save the patient's life, the ethics of sterilizing a young person suffering from the poorly defined psychiatric disorder called gender dysphoria, or amputating healthy parts of their body, are far more questionable.

### Evidence Showing the Harmful Effects of Wrong-Sex Hormones

WPATH members adhere to the belief that attempting to help a patient overcome their feelings of gender incongruence and reconcile with their birth sex amounts to conversion therapy.<sup>81</sup> Therefore, the mental and medical professionals inside the leading transgender health group advocate for affirmation alongside invasive and harmful hormonal and surgical interventions as the first and only line of treatment for patients, including minors and the severely mentally ill, despite knowing the detrimental effects.

Inside the WPATH forum, there were plenty of discussions about the effects of cross-sex hormones on the sexual function of natal females, as well as natal males who had been allowed to go through puberty and were, therefore, able to orgasm.

For example, in the discussion thread dated March 24, 2022, a nurse practitioner asked about a "young patient" who developed pelvic inflammatory disease after three years of testosterone. The natal female "has atrophy with the persistent yellow discharge we often see as a result," the nurse wrote. Vaginal atrophy is the thinning, drying, and inflammation of the vaginal walls that occurs when a woman has less estrogen, typically after menopause. For many women, vaginal atrophy not only makes intercourse painful but also leads to distressing urinary symptoms.

Pelvic Inflammatory Disease (PID) is a serious condition which can lead to severe and potentially life-threatening health issues, including the spread of infection to other body parts as well as abscesses of the ovaries and fallopian tubes. It significantly raises the risk of ectopic pregnancy, which can also be life-threatening. As well, PID can negatively impact fertility. The longer PID remains untreated, the higher the likelihood of enduring

81 Ibid (n.52)

serious long-term health problems and infertility, and prolonged PID infections can result in permanent scarring of the reproductive organs. The condition can result in the need for a hysterectomy.

In the replies, one WPATH member shared a story about young natal females developing “pelvic floor dysfunction, and even pain with orgasm.” A trans-identified natal female lawyer and prominent trans activist shared a personal account of developing a condition after years on testosterone that caused “splits in the skin which bled, and were excruciating.” And another trans-identified natal female member described “bleeding after penetrative sex,” painful orgasms, and an atrophied uterus.

Natal males don’t fare any better on estrogen, either. When a doctor posted asking for “any insight as to why some transwomen may experience significant pain with erections post hormone therapy,” the replies indicated that this is not an uncommon problem.

A trans-identified natal male counselor confirmed having experienced painful erections while taking estradiol and described “trying to avoid having them because of this,” explaining that even when the erections were not painful, “they were physically uncomfortable and not pleasurable.” A registered nurse told of natal male patients who described erections as “feeling like broken glass.”

This is the treatment pathway WPATH endorses for adolescents. These exchanges indicate that gender-affirming healthcare providers are knowingly permitting young patients to compromise their sexual function when they do not have the maturity or experience to comprehend the implications of such a decision in the context of a long-term relationship. These youth are being allowed to sacrifice a crucial component of their sexual identity before they have any understanding of the impact the loss will have on their adult life.

Doctors on the forum also found that cross-sex

hormones had severe adverse effects on some young people. In December 2021, a doctor described a 16-year-old patient who had developed large liver tumors after being on norethindrone acetate to suppress menstruation for several years and testosterone for one year. “Pt found to have two liver masses (hepatic adenomas) - 11x11cm and 7x7cm - and the oncologist and surgeon both have indicated that the likely offending agent(s) are the hormones,” the doctor wrote.

Another doctor replied to this with an anecdote about a female colleague who, after about 8-10 years of taking testosterone, developed hepatocarcinomas. “To the best of my knowledge, it was linked to his hormone treatment,” said the doctor, who had no more details because the cancer was so advanced that her colleague died a couple of months later.

The risk of female patients on testosterone developing hepatocellular carcinomas has been noted before. In 2020, *The Lancet* published a case study of a 17-year-old trans-identified natal female with a large hepatocellular carcinoma (HCC), the most common type of primary liver cancer which is most often seen in men and people with chronic liver diseases, such as cirrhosis caused by hepatitis B or hepatitis C infection. The 17-year-old had been on testosterone for 14 months, but her team had advised her to stop taking the hormone due to the “possible effects it might be having on the tumour.” The outcome for the patient is not known, but the case study concluded by stating that the “relationship between exogenous testosterone and development and progression of HCC in peripubertal transgender patients is unknown.”<sup>82</sup>

Researchers have also documented a second unusual case of liver cancer in a trans-identified natal female. This patient was 47 years old at the time of diagnosis and was found to have cholangiocarcinoma, a rare cancer of the bile duct that is normally only seen in older people.<sup>83</sup>

82 Lin, A. J., Baranski, T., Chaterjee, D., Chapman, W., Foltz, G., & Kim, H. “Androgen-Receptor-Positive Hepatocellular Carcinoma in a Transgender Teenager Taking Exogenous Testosterone.” *The Lancet* 396, no. 10245 (2020): 198. [https://www.thelancet.com/article/S0140-6736\(20\)31538-5/fulltext](https://www.thelancet.com/article/S0140-6736(20)31538-5/fulltext)

83 Pothuri, V. S., Anzelmo, M., Gallaher, E., Ogunlana, Y., Aliabadi-Wahle, S., Tan, B., Crippin, J. S., & Hammill, C. H. “Transgender Males on Gender-Affirming Hormone Therapy and Hepatobiliary Neoplasms: A Systematic Review.” *Endocrine Practice* 29, no. 10 (2023/10/01/ 2023): 822-29. <https://pubmed.ncbi.nlm.nih.gov/37286102/>.

The relatively unexpected ages in these two cases, absence of risk factors, and known association between exogenous testosterone and liver tumors prompted an investigation of existing literature on the relationship between gender-affirming hormone therapy and cancer of the liver. The systematic review was inconclusive, however, due to lack of available evidence. “The available evidence is limited by the rarity of these tumor types [and] the historical lack of access to [gender-affirming hormone therapy].”<sup>84</sup>

It is not only liver cancer that is of concern for natal females taking exogenous testosterone. A 2022 cohort study demonstrated a high percentage of abnormal Pap tests in natal females receiving testosterone. The researchers concluded that “[t]estosterone seems to induce changes in squamous cells and shifts in vaginal flora.”<sup>85</sup> Other studies have suggested links between testosterone use and increased risk of heart attacks.<sup>86,87</sup>

In light of the significant increase in teenage girls and young women identifying as transgender and seeking testosterone therapy in recent years, coupled with WPATH’s gender-affirming care model, there is an urgent need to investigate any potential life-threatening connections. Furthermore, the “informed consent model of care” endorsed by WPATH has streamlined access to this potent and potentially deadly hormone. In some states, for women as young as 18, it is as straightforward as signing a consent form at Planned Parenthood.<sup>88</sup>

Also, a 2018 study conducted by Kaiser Permanente

found that natal males on estrogen had a 5.2% risk of a blood clot in the lungs or legs, a heart attack, or a stroke within a mean of 4 years after initiating estrogen (but the increased risk begins as early as one year), and the risks rise the longer a trans-identified natal male takes estrogen.<sup>89</sup>

The paucity of good quality research in the field of gender medicine was exposed in the 2020 Cochrane Library systematic review of the scientific literature on the safety and efficacy of cross-sex hormone therapy for natal males.<sup>90</sup> The review revealed that not one of the studies within the entire body of literature even reached the classification of very low quality, and as a result, not a single study fulfilled the inclusion criteria set by the review.

“Despite more than four decades of ongoing efforts to improve the quality of hormone therapy for [natal males] in transition, we found that no RCTs or suitable cohort studies have yet been conducted to investigate the efficacy and safety of hormonal treatment approaches for [natal males] in transition,” wrote the researchers. “The evidence is very incomplete, demonstrating a gap between current clinical practice and clinical research.”

Given the lack of scientific literature to indicate that cross-sex hormone therapy is safe and effective, as well as the number of known negative side effects and the possible serious negative outcomes, it is unethical for WPATH to advocate for minors and the severely mentally ill to bypass psychotherapy and have immediate access to these powerful drugs.

84 Ibid (n.83)

85 Lin, L. H., Zhou, F., Elishaev, E., Khader, S., Hernandez, A., Marcus, A., & Adler, E. “Cervicovaginal Cytology, Hpv Testing and Vaginal Flora in Transmasculine Persons Receiving Testosterone.” [In eng]. *Diagn Cytopathol* 50, no. 11 (Nov 2022): 518-24. <https://doi.org/10.1002/dc.25030>.

86 Alzahrani, T., Nguyen, T., Ryan, A., Dwairy, A., McCaffrey, J., Yunus, R., Forgione, J., Krepp, J., Nagy, C., Mazhari, R., & Reiner, J. (2019). Cardiovascular Disease Risk Factors and Myocardial Infarction in the Transgender Population. *Circulation: Cardiovascular Quality and Outcomes*, 12(4). <https://doi.org/10.1161/circoutcomes.119.005597>

87 Nota, N. M., Wiepjes, C. M., De Blok, C. J. M., Gooren, L. J. G., Kreukels, B. P. C., & Den Heijer, M. (2019). Occurrence of Acute Cardiovascular Events in Transgender Individuals Receiving Hormone Therapy. *Circulation*, 139(11), 1461-1462. <https://doi.org/10.1161/circulationaha.118.038584>

88 “I Want to Transition. How Old Do You Have to Be to Get Hrt?” Planned Parenthood, 2023, <https://www.plannedparenthood.org/blog/i-want-to-transition-how-old-do-you-have-to-be-to-get-hrt>.

89 Getahun, D., Nash, R., Flanders, W. D., Baird, T. C., Becerra-Culqui, T. A., Cromwell, L., Hunkeler, E., Lash, T. L., Millman, A., Quinn, V. P., Robinson, B., Roblin, D., Silverberg, M. J., Safer, J., Slovis, J., Tangpricha, V., & Goodman, M. (2018). Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study. *Ann Intern Med*, 169(4), 205-213. <https://doi.org/10.7326/m17-2785n>

90 Haupt, C., Henke, M., Kutschmar, A., Hauser, B., Baldinger, S., Saenz, S. R., & Schreiber, G. (2020). Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women. *Cochrane Database of Systematic Reviews*(11). <https://doi.org/10.1002/14651858.CD013138.pub2>

### Doctors Improvising and Experimenting

As already shown, WPATH advocates for an unregulated experiment to be conducted on minors who are experiencing gender-related distress. There is no reliable evidence to support the safety and efficacy of puberty suppression for trans-identified adolescents. However, there is further evidence in the files that WPATH members are engaged in improvisation and experimentation rather than rigorous science.

For example, in the discussion threads concerning the debilitating reproductive organ pain experienced by both male and female patients due to hormone therapy, the advice is consistently anecdotal and little more than guesswork. In the thread about the young natal female who had required emergency room care for pelvic inflammatory disease (PID) after three years on testosterone, the New York nurse told the group that the estrogen cream “appears to have stopped working,” and the patient has persistent yellow discharge. “Has anyone had luck with estrace tablets vs cream?” the nurse asked, seemingly in lieu of consulting scientific literature.

The replies contain vague anecdotal recommendations that topical creams can help a few patients, and a couple of trans-identified natal females tell of remedies that helped relieve some of their symptoms. A Michigan family physician tells the forum of the success she had treating two natal females with an antispasmodic drug to relieve their painful orgasms, specifying that the drug should be taken 30-60 minutes before orgasm.

However, anecdotes are not science, and no one in the forum provided links to actual scientific literature providing evidence-based recommendations for managing these painful iatrogenic symptoms.

The reason for this is there is no reliable science to consult. A 2021 review of the relevant literature states that

the “field of transgender medicine is relatively new, and little is known of the effects of testosterone therapy,” but did note that natal females on testosterone therapy frequently experience symptoms of vaginal atrophy similar to those of the post-menopausal state, including dryness, irritation, bleeding with vaginal penetration (sex or medical examination), and dyspareunia (pain during intercourse). The authors acknowledge that these symptoms can have “a substantial impact on quality of life” and may require local estrogen-based therapy, but “the efficacy of this approach has not been documented” in trans-identified natal females.<sup>91</sup>

Worse, a 2023 study found that testosterone use increases a natal female’s libido while at the same time increasing pain during intercourse, with over 60% of participants reporting genital pain or discomfort during sexual activity. The researchers noted that the majority of trans-identified natal females experience “vulvovaginal” pain during sexual activity and concluded that “[g]iven this high burden, there is an urgent need to identify effective and acceptable interventions for this population.”<sup>92</sup>

In the thread discussing an endocrinologist’s question about why some trans-identified natal males experience “significant pain with erections post hormone therapy” and whether this pain was likely to persist after undergoing vaginoplasty, the responses were once again vague and anecdotal, with WPATH members speculating that the discomfort could be linked to factors such as tissue atrophy and thinning of penile skin, and infrequent erections. Some members even admitted to never addressing this concern with their patients. A trans-identified natal male counselor shared a personal anecdote about experiencing this symptom and indicated that it was resolved through penis amputation.

“My guess (and it’s just a guess, I’m not a medical

91 Krakowsky, Y., Potter, E., Hallarn, J., Monari, B., Wilcox, H., Bauer, G., Ravel, J., & Prodger, J. L. “The Effect of Gender-Affirming Medical Care on the Vaginal and Neovaginal Microbiomes of Transgender and Gender-Diverse People.” [In eng]. *Front Cell Infect Microbiol* 11 (2021): 769950. <https://doi.org/10.3389/fcimb.2021.769950>.

92 Tordoff, D. M., Lunn, M. R., Chen, B., Flentje, A., Dastur, Z., Lubensky, M. E., Capriotti, M., & Obedin-Maliver, J. “Testosterone Use and Sexual Function among Transgender Men and Gender Diverse People Assigned Female at Birth.” [In eng]. *Am J Obstet Gynecol* (Sep 9 2023). <https://doi.org/10.1016/j.ajog.2023.08.035>.

person) would be that the pain is related to erectile tissue in [the] penis and that the removal of that tissue during vaginoplasty addresses the problem,” said the counselor.

In another thread, a nurse practitioner told the group about a female patient who identified as non-binary and was requesting “masculinizing hormone therapy.” The patient had asked about taking Finasteride, a 5 $\alpha$ -reductase inhibitor used to treat prostatic hyperplasia (BPH) and male pattern hair loss, to prevent “bottom growth.”

Bottom growth is a term used to describe the permanent enlargement of the clitoris due to testosterone use. This can cause significant pain and sensitivity.<sup>93</sup> The replies are once again a chorus of speculation, with no one providing any scientific literature to back up the experimental use of the drug for this purpose. One doctor from Massachusetts said she would “be interested to hear if others have tried using it to block clitoral growth,” and a family physician from Manchester, who had also had a patient request the drug, had not been able to find any evidence to support using it for this reason. “Any resources, evidence or advice would be appreciated,” he concluded.

In fact, Finasteride is mentioned in SOC8 as a possible treatment option for undesired male pattern hair loss in female patients on testosterone, but the authors caution that it “may impair clitoral growth and the development of facial and body hair.”

There were plenty of examples of improvisation in our leaked panel discussion as well, where Dr. Cecile Ferrando, a surgeon, tells the assembled WPATH members that she experiments with “underdosing” natal females with testosterone. She explains that these females desire “cessation of menses” but not virilization. Ferrando added that these young women in their twenties “err on the masculine side of the spectrum but don’t want to be fully masculinized.” The gender surgeon tells the group that her experimental use of a Schedule III controlled substance improves the young women’s “state of being” and “sense of

wellbeing.”

It’s not just adults who are being experimented on either. Massey shares an account of a confused young patient being treated by equally confused healthcare providers. The child has been on puberty blockers for about two years, and her pediatric endocrinologist wants her to stay on a little longer. “The kid is vacillating, really not wanting facial hair,” but unsure about having menstrual cycles, “and kind of vacillates about whether breast development, chest development, bothers them or not and which pronouns they use,” explains Massey.

“So, is there more, um, benefit of staying on blockers or letting the kid switch back to their endogenous estrogen? Or is it better to go low-dose testosterone or what? You know, and at what point in time?” asks the confused therapist.

“So, if the kid doesn’t want facial hair but maybe doesn’t mind their chest growing, and they’re planning on having chest surgery anyways. So we may want to be creative in how we help folks approach these situations that are complex,” Massey concludes. It is safe to say that most parents do not want confused doctors being “creative” when it comes to performing life-altering medical interventions on their children.

Metzger describes putting 13-year-olds on cross-sex hormones as “like a journey,” with the child’s doctor “coming along for the ride.” He explains that he lets his teenage patients lead when it comes to their hormone doses, asking them each time they show up for an appointment what they want to do with their hormones. He noted that “kids do shift with time, particularly the non-binary kids,” who often end up not wanting to be as masculine as they first thought. “They find that there’s a happy dose that’s gotten rid of their periods or whatever, and that they’re happy on that dose,” he added. While it might seem odd to put a child in the driving seat in this way, it is entirely consistent with WPATH’s affirmative

93 Wierckx, K., Van Caenegem, E., Schreiner, T., Haraldsen, I., Fisher, A., Toye, K., Kaufman, J. M., & T’Sjoen, G. (2014). Cross-Sex Hormone Therapy in Trans Persons Is Safe and Effective at Short-Time Follow-Up: Results from the European Network for the Investigation of Gender Incongruence. *The Journal of Sexual Medicine*, 11(8), 1999-2011. <https://doi.org/10.1111/jsm.12571>

model of care, which strives to help patients achieve their unique, and often shifting, “embodiment goals.”

However, despite clear evidence that gender-affirming healthcare providers are experimenting on the patients in their care, WPATH’s official stance is that these treatments are evidence-based. Interestingly, WPATH deliberately refrains from using the term “experimental” in its SOC8, all the while acknowledging the absence of evidence to support its recommendations.

For example, in the adolescent chapter, when addressing all the uncertainties surrounding whether or not gender identity is fixed from birth or part of a “developmental process,” the authors concede that “[f]uture research would shed more light on gender identity development if conducted over long periods of time with diverse cohort groups.”<sup>94</sup> In other words, there is no science to support the idea that gender identity is fixed or to justify permanently altering a young person’s body using drugs and surgeries. Therefore, the whole treatment protocol is “experimental,” except for the fact that it doesn’t even meet that low bar because a real experiment involves control groups and diligent follow-up, neither of which occurs in WPATH’s field of gender-affirming medicine. Of note, every European systematic review of the evidence for adolescent sex-trait modification interventions to date has concluded that the treatments are experimental.

What’s more, WPATH is aware that this experiment is not just confined to minors. In the adult chapter of SOC8, the authors state that the “criteria in this chapter have been significantly revised from SOC-7 to reduce requirements and unnecessary barriers to care. It is hoped that future research will explore the effectiveness of this model.”<sup>95</sup>

In the aforementioned section discussing the possible

use of Finasteride to prevent unwanted side effects of testosterone use in females, the authors conclude that “[s]tudies are needed to assess the efficacy and safety of 5 $\alpha$ -reductase inhibitors in transgender populations.” Similar phrasing, synonymous with “experimental,” can be found throughout SOC8.

The deliberate avoidance of the term “experimental” is due to the fact that experimental medicine is not covered by health insurance, and one of the primary objectives of WPATH’s SOC8 is to secure insurance coverage, an aim the leading transgender health group prioritizes over adhering to best medical practices.

### WPATH Members Causing Surgical Harm

WPATH members are also causing surgical harm to their patients, including minors and those suffering from severe mental illness. In a discussion that took place in May 2023, a Colombian surgeon was unsure how to proceed with a 14-year-old natal male who was requesting vaginoplasty surgery.

As previously stated, vaginoplasty is a major surgery that entails amputating the penis and using the penile tissue to create a pseudo-vagina. The procedure comes with a high complication rate, a long recovery time, and requires lifelong dilation of the surgical site to prevent the wound from closing.

Also, dilation, the physical insertion of a dilator to maintain the depth of the cavity, can cause discomfort and pain and must be performed three times a day in the immediate post-op period. This can take as much as 2 to 2.5 hours a day.<sup>96</sup> As the patient recovers, dilation needs to gradually taper off, but the surgical site needs to be dilated once a week for life.

Dr. Christine McGinn replied, recommending that he “tread lightly” because many hospitals are now banning

94 Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., De Vries, A. LC., Deutsch, M. B., Ettner, R., et al. “Standards of Care for the Health of Transgender and Gender Diverse People, Version 8.” *International Journal of Transgender Health* 23, no. sup1 (2022): S45. <https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644>.

95 Ibid (n.94 p.33)

96 “Use It or Lose It: The Importance of Dilation Following Vaginoplasty.” *MTF Surgery*, 2023, <https://www.mtsurgery.net/dilation.htm>.



surgeries for those under 18. McGinn reported performing about 20 vaginoplasties on patients under 18 over a 17-year period and confessed that “not all...had perfect outcomes,” adding that, “None of these patients have regretted their decision *that I am aware of.*” (emphasis added)

McGinn then explained that the “ones who had trouble” were the ones who were unable to adhere to the dilation schedule and suffered from vaginal stricture as a result, adding that patients over 18 can have the same dilation difficulties.

Vaginal stricture, or neovaginal stenosis, is a common complication following penile inversion vaginoplasty. A 2021 study found that almost 15% of males who underwent vaginoplasty at Mount Sinai Hospital had to have one or more revision surgeries due to neovaginal stenosis, 73.5% of whom had been unable to adhere to the post-op dilation schedule.<sup>97</sup> Vaginoplasty revision surgery is more difficult due to scar tissue, which also makes dilation post-revision surgery more challenging and painful.<sup>98</sup>

Neovaginal stenosis is just one of many complications that can arise after vaginoplasty. A 2018 review of the data on vaginoplasty complications provides a long list of all the possible complications, ranging from minor, aesthetic issues to severe complications such as rectal injuries and serious urinary dysfunction.<sup>99</sup>

Also, in May 2023, a gynecologist in the WPATH forum described a patient who, after penile inversion vaginoplasty, was leaking prostate secretions through the urethra and was finding it bothersome. The replies inform the gynecologist that there is no remedy, but one nursing lecturer, who self-described as a “woman of trans experience,” suggested telling the distressed patient to “enjoy the ride,” adding, “It’s the ultimate physical sign of orgasm...what’s not to like?”

These exchanges prove that WPATH surgeons are

aware of these adverse outcomes post-vaginoplasty and yet still not only recommend minors undergo such drastic surgeries but also do no follow-up to monitor how the young patients fare later in life. An ethical surgeon performing any experimental procedures on minors would only do so in cases of the highest need, in the strictest of clinical trial settings, and with diligent follow-up of patients well into adulthood to evaluate the impact of such a drastic procedure on their adult functioning. A surgeon who is truly dedicated to delivering the highest quality of care would express genuine concern for their patient’s capacity to establish and maintain long-term intimate relationships following genital surgery. But saying “that I am aware of” indicates that McGinn is just assuming the young patients recover well while having no way of knowing if the experiment resulted in a positive outcome.

But despite having no evidence that genital surgery improves life for natal males who undergo the procedure as adolescents, McGinn still believes that the ideal time for a young person to have this major, life-altering surgery is “the summer before their last year of high school,” a sentiment shared by WPATH President Bowers, who in the replies expressed reluctance to perform the procedure on someone so young but agreed that “sometime before the end of high school does make some sense in that they are under the watch of parents in the home they grew up in.”

As well, there is evidence in the files of members doing surgical harm to severely mentally ill patients. In an undated message thread, a therapist expresses concern about referring her “trans clients with serious mental illness” for surgery due to difficulty in predicting their future stability, “in particular, given the extensive recovery period and ‘postnatal’ care required for vaginoplasty.”

A California marriage and family therapist replied, saying it depends on many factors, such as how much

97 Kozato, A., Karim, S., Chennareddy, S., Amakiri, U, O., Ting, J., Avanesian, B., Safer, J. D., et al. “Vaginal Stenosis of the Neovagina in Transfeminine Patients after Gender-Affirming Vaginoplasty Surgery.” *Plastic and Reconstructive Surgery – Global Open* 9, no. 10S (2021). [https://journals.lww.com/prsgo/fulltext/2021/10001/vaginal\\_stenosis\\_of\\_the\\_neovagina\\_in\\_transfeminine.103.aspx](https://journals.lww.com/prsgo/fulltext/2021/10001/vaginal_stenosis_of_the_neovagina_in_transfeminine.103.aspx).

98 “Vaginal Depth and Avoiding Stenosis.” *Gender Bands*, 2021, <https://www.genderbands.org/post/marinating-vaginal-depth-and-avoiding-stenosis>.

99 Ferrando, C. A. “Vaginoplasty Complications.” [In eng]. *Clin Plast Surg* 45, no. 3 (Jul 2018): 361-68. <https://pubmed.ncbi.nlm.nih.gov/29908624/>.



support the mentally ill person has, whether they have a safe place to recover, and whether or not they understand instructions such as “dilute, wash, monitor.” She added that in the last 15 years, she had only declined to write one referral letter, and that was mainly because “the person evaluated was in active psychosis and hallucinated during the assessment session.”

“Other than that - nothing - everyone got their assessment letter, insurance approval, and are living (presumably) happily ever after,” said the therapist, who has referred for genital surgery people diagnosed with major depressive disorder, c-PTSD, and who are homeless.

Here, the therapist’s use of the word “presumably,” like the previous surgeon’s “that I am aware of,” indicates no systematic follow-up of patients, which would be reasonable to expect from a surgeon who knows he or she is doing something risky, invasive and experimental. Without follow-up, there is no way to know whether the severely mentally ill person was able to cope with the arduous 2+ hours a day of post-op dilation, the long recovery period, and the lifelong impact of the surgery on the patient’s physical health and ability to form intimate relationships. WPATH-affiliated surgeons do not appear to have even the slightest curiosity about the outcome for such patients.

While the therapist was right to be concerned about the level of support patients have during the immediate post-op period, her contribution demonstrates the myopic thinking of gender-affirming healthcare providers. WPATH members typically focus on short-term patient satisfaction from the drastic, life-altering interventions they endorse and appear to have little concern for how the patient will fare in 20, 30, or 40 years.

WPATH members are also willing to allow people with serious degenerative diseases to undergo sex trait

modification surgeries. One New Jersey nurse practitioner in the files asked for advice regarding a 22-year-old natal male with Becker Muscular Dystrophy who wished to begin taking estrogen and later undergo vaginoplasty. While the nurse could find no obstacles to proceeding with “gender affirming hormone therapy,” concerns were raised about the potential risks associated with anesthesia during the surgical procedure. Notably, there was no indication of the nurse expressing concern about the impact of vaginoplasty on the patient’s overall health or ability to manage the extended post-operative recovery period.

Others inside the forum object to surgical restrictions based on high body mass index (BMI). It is widely recognized that obesity increases the risks associated with surgery, leading to complications such as prolonged operative time, increased risk of surgical site infections, and various other complications.<sup>100,101</sup> Therefore, it is standard practice for surgeons to have a BMI cap for elective surgeries.<sup>102</sup>

However, inside WPATH, some members are unhappy about obese female patients being denied elective bilateral mastectomies. A research associate within the group suggested that this denial is the result of “systemic fatphobia” and challenged the conventional belief that the patients’ obesity directly contributes to adverse outcomes, instead suggesting that it was the result of “weight bias” influencing how patients are cared for and operated on. While acknowledging the “high prevalence of eating disorders in trans individuals,” this WPATH member expressed concern that withholding surgery could potentially exacerbate these issues.

A Washington social worker contributed an anecdote about a “client seeking top surgery” who had been told to lose weight. This apparently triggered “disordered eating.”

100 Tsai, A., & Schumann, R. (2016). Morbid obesity and perioperative complications. *Curr Opin Anaesthesiol*, 29(1), 103-108. <https://doi.org/10.1097/aco.0000000000000279>

101 Osman, F., Saleh, F., Jackson, T. D., Corrigan, M. A., & Cil, T. (2013). Increased Postoperative Complications in Bilateral Mastectomy Patients Compared to Unilateral Mastectomy: An Analysis of the NSQIP Database. *Annals of Surgical Oncology*, 20(10), 3212-3217. <https://doi.org/10.1245/s10434-013-3116-1>

102 Farquhar, J. R., Orfaly, R., Dickson, M., Lazare, D., Wing, K., & Hwang, H. (2016). Quantifying a care gap in BC: Caring for surgical patients with a body mass index higher than 30. *British Columbia Medical Journal*, 58(6).

The social worker was considering contacting Dr. Mosser, a San Francisco surgeon and WPATH member, who does not have a BMI limit. Dr. Mosser's website states that he has performed elective bilateral mastectomies on patients with a BMI as high as 65.<sup>103</sup>

In 2022, Dr. Sidhbh Gallagher, a WPATH-affiliated surgeon famous for making quirky TikTok videos promoting her services to her hundreds of thousands of young followers, in which she refers to bilateral mastectomies as “yeet the teets,” received backlash from several obese patients who claim to have experienced severe post-op complications.<sup>104,105</sup> One young patient told a harrowing tale of the surgical incision opening and a resulting infection that almost proved fatal.<sup>106</sup>

### Dismantling Guardrails

WPATH's aversion to caution and dislike of psychiatric gatekeeping is evident in the files. In an undated thread, a psychotherapist expressed her dissatisfaction with the group regarding a surgeon's requirement of two referral letters from her before amputating the healthy breasts of a 17-year-old girl. To the psychotherapist, this seemed like “extra extra gatekeeping.”

The letters appear to be little more than a formality for insurance purposes, but in the replies, a therapist suggested the reason could be that the insurance company wanted evidence that the “status of the client” had not changed over time.

However, the rest of the replies are a chorus of agreement that the request is unnecessary gatekeeping, with one even suggesting reporting the insurer to the local state regulator “for their clinically unsound coverage determination requirements.”

A Florida non-binary counselor with they/them

pronouns replied, offering her services. She told the therapist that she provides consultation specifically regarding letter writing. “If you're interested in consultation with a provider of lived experience, I'm happy to chat further,” said the counselor. “I've written quite a few second letters and have written letters for minors as well,” she added.

In another undated thread, a Virginia therapist with “several trans clients with serious mental illness” such as “bipolar disorder and autism or schizoaffective disorder” asked the group for advice on what criteria to use to determine whether or not a patient was ready for surgery. She was particularly concerned about “clients” with serious mental illness being capable of adhering to “post-surgical dilation protocols.”

A California therapist replied that “as gender affirmative practitioners, we always consider harm reduction as our primary lens,” meaning it is necessary to ask “what will happen to these patients if they do NOT undergo their affirmative treatment, which is also a medical necessity.” This therapist said she was personally “not invested” in SOC7's requirement that mental illness be “well controlled” before the patient is allowed to consent to surgeries such as vaginoplasty and bilateral mastectomies. In fact, this thinking was in line with WPATH's official stance, as the group removed the requirement from its SOC8.

A trans-identified natal male therapist joined the discussion to say that according to WPATH's SOC7, the “letter of support” was primarily to establish the persistence of the patient's gender dysphoria and that “denying necessary surgical care (even for the severely mentally ill) encroaches strongly on a patient's autonomy.”

This shift towards viewing the involvement of mental

103 Mosser, S. Top Surgery Eligibility FAQ. Gender Confirmation Center. <https://www.genderconfirmation.com/eligibility-faq/#:-:text=Mosser%20does%20not%20have%20a,the%20patient%27s%20primary%20care%20physician>

104 Gallagher, S. (2024). GenderSurgeon. <https://www.tiktok.com/@gendersurgeon?lang=en>

105 Buttons, C. (2024). TikTok Doc's Trans Patients Post More Gruesome Stories Of Post-Op Complications. The Daily Wire. <https://www.dailywire.com/news/tiktok-docs-trans-patients-post-more-gruesome-stories-of-post-op-complications>

106 Rylan. (2022). Top Surgery with Dr. Gallagher Almost Cost Me My Life. Medium. <https://rylan545.medium.com/top-surgery-with-dr-gallagher-almost-cost-me-my-life-d68cda71c543>

health professionals as superfluous began with Dr. Richard Green commissioning HBGDA's SOC6 immediately after Dr. Stephen Levine's SOC5 had specified two referral letters were needed before starting hormones. Whereas Levine advocated for guardrails to be placed around access to medical transition in an effort to minimize regret, WPATH, since Green's day, has been intent on dismantling those safety measures.

### WPATH Members Trivializing Detransitioners' Stories of Harm

Gender-affirming healthcare providers have always maintained that the regret rate for sex-trait modification interventions is very low, but this belief is based on deeply flawed research.<sup>107,108,109</sup> Due to sloppy, inadequate follow-up, the true detransition rate is unknown, but recent studies indicate it is rising.<sup>110,111,112,113</sup> Several small studies provide valuable insights into the detransition experience.<sup>114,115,116,117</sup> As well, an increasing number of young people are speaking out about the harm they experienced at the hands of gender-affirming healthcare

providers.<sup>118,119,120</sup> Yet many WPATH members in the forum remain in denial about the damage done, dismissing or trivializing the lifetime of regret now faced by many young people.

In response to a post by a Washington DC psychologist about a “distracted and angry” 17-year-old detransitioned girl who had been on testosterone for more than two years and felt she was “brainwashed,” several WPATH members appear in the replies. There is talk of detransition being just another step in a patient’s “gender journey” and not necessarily involving regret. By this self-serving logic, it is impossible for clinicians practicing the affirmative model to ever be wrong in their diagnosis or treatment decisions.

The notion of the “gender journey” to describe regret and detransition is used to insulate gender-affirming clinicians from criticism and accountability. Within the realm of gender-affirming care, as long as the healthcare provider affirms the regret and detransition phase as part of the “journey,” any potential errors or misjudgments are considered acceptable.

As well, on more than one occasion, the WPATH

- 107 Bustos, V. P., Bustos, S. S., Mascaro, A., Del Corral, G., Forte, A. J., Ciudad, P., Kim, E. A., Langstein, H. N., & Manrique, O. J. “Regret after Gender-Affirmation Surgery: A Systematic Review and Meta-Analysis of Prevalence.” [In eng]. *Plast Reconstr Surg Glob Open* 9, no. 3 (Mar 2021): e3477. <https://doi.org/10.1097/gox.00000000000003477>.
- 108 “At What Point Does Incompetence Become Fraud?” *Genspect*, 2022, <https://genspect.org/at-what-point-does-incompetence-become-fraud/>.
- 109 Dhejne, C., Öberg, K., Arver, S., & Landén, M. “An Analysis of All Applications for Sex Reassignment Surgery in Sweden, 1960-2010: Prevalence, Incidence, and Regrets.” [In eng]. *Arch Sex Behav* 43, no. 8 (Nov 2014): 1535-45. <https://doi.org/10.1007/s10508-014-0300-8>.
- 110 Cohn, J. “The Detransition Rate Is Unknown.” *Archives of Sexual Behavior* 52, no. 5 (2023): 1937-52. <https://doi.org/10.1007/s10508-023-02623-5>. <https://dx.doi.org/10.1007/s10508-023-02623-5>.
- 111 Irwig, M. S. “Detransition among Transgender and Gender-Diverse People—an Increasing and Increasingly Complex Phenomenon.” *The Journal of Clinical Endocrinology & Metabolism* 107, no. 10 (2022): e4261-e62. <https://doi.org/10.1210/clinem/dgac356>.
- 112 Hall, R., Mitchell, L., & Sachdeva, J. “Access to Care and Frequency of Detransition among a Cohort Discharged by a UK National Adult Gender Identity Clinic: Retrospective Case-Note Review.” [In eng]. *BJPsych Open* 7, no. 6 (Oct 1 2021): e184. <https://doi.org/10.1192/bjo.2021.1022>.
- 113 Boyd, I., Hackett, T., & Bewley, S. “Care of Transgender Patients: A General Practice Quality Improvement Approach.” [In eng]. *Healthcare (Basel)* 10, no. 1 (Jan 7 2022). <https://doi.org/10.3390/healthcare10010121>.
- 114 Littman, L. (2021). Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners. *Archives of Sexual Behavior*, 50(8), 3353-3369. <https://doi.org/10.1007/s10508-021-02163-w>
- 115 Mackinnon, K. R., Gould, W. A., Enxuga, G., Kia, H., Abramovich, A., Lam, J. S. H., & Ross, L. E. (2023). Exploring the gender care experiences and perspectives of individuals who discontinued their transition or detransitioned in Canada. *PLOS ONE*, 18(11), e0293868. <https://doi.org/10.1371/journal.pone.0293868>
- 116 Littman, L., O'Malley, S., Kerschner, H., & Bailey, J. M. (2023). Detransition and Desistance Among Previously Trans-Identified Young Adults. *Archives of Sexual Behavior*. <https://doi.org/10.1007/s10508-023-02716-1>
- 117 Vandenbussche, E. (2022). Detransition-Related Needs and Support: A Cross-Sectional Online Survey. *Journal of Homosexuality*, 69(9), 1602-1620. <https://doi.org/10.1080/00918369.2021.1919479>
- 118 Reddit, 2023, <https://www.reddit.com/r/detrans/>.
- 119 “‘I Literally Lost Organs’: Why Detransitioned Teens Regret Changing Genders.” *New York Post*, 2022, <https://nypost.com/2022/06/18/detransitioned-teens-explain-why-they-regret-changing-genders/>.
- 120 “Why This Detransitioner Is Suing Her Health Care Providers.” *Public*, 2023, [https://public.substack.com/p/why-this-detransitioner-is-suing?utm\\_source=%2Fsearch%2Fmichelle&utm\\_medium=reader2](https://public.substack.com/p/why-this-detransitioner-is-suing?utm_source=%2Fsearch%2Fmichelle&utm_medium=reader2).

members pass the blame to the young person. Another psychologist talks of a female patient who is still in high school and has decided to detransition, claiming that the girl “acknowledges that [she] was the driver in getting [her] to this point.”

WPATH President Bowers then echoed this psychologist’s opinion, stating that all medical treatments have regret rates that are typically much higher than for gender transition, and “patients need to own and take active responsibility for medical decisions, especially those that have potentially permanent effects.” Bowers added that “legislatures and the media [do not] go after breast augmentation, tubal ligation or facelifts.” Here, Bowers inadvertently concedes that sex-trait modification procedures are elective, cosmetic procedures, like facelifts and breast augmentation, which also often result in lifelong sterility, like tubal ligation.

However, a minor does not have the cognitive capacity to understand those “potentially permanent effects” and, therefore, cannot give cognitive consent, and the leaked panel discussion proves that WPATH members are aware of that fact. In many cases, a person suffering from severe mental illness also does not have the necessary decision-making capacity to assess the risks and life-long consequences of the treatment. In these circumstances, responsibility rests with the healthcare professionals who misdiagnosed the patient and neglected their duty to secure proper informed consent. In no other branch of medicine is the patient blamed for consenting to a treatment based on a misdiagnosis.

Furthermore, in the United States, it is highly unlikely that any medical professional would permit a healthy adolescent girl to provide consent for tubal ligation. This is because it is widely recognized that although many teenagers may strenuously insist that they never want children, such feelings are likely to change over time as the

young person matures and their priorities shift. Metzger’s “oh, the dog’s not doing it for you now” remark during the panel proves that he and his fellow WPATH panelists understand this perfectly well.

If there were suddenly a surge of teenagers being given vasectomies and tubal ligation on demand, or if plastic surgeons were selling breast augmentation and facelifts to adolescents as a remedy for their mental disorders, it is certain that both the media and legislatures would weigh in on the issue.

### Suspiciously Low Regret Rates

Bowers’s comment that “all medical treatments have a regret rate higher than medical transition” should give WPATH members pause for thought. The statement, on the surface, appears to be true. A recent systematic review of regret rates following “gender affirmation” surgery found regret to be less than 1% for natal females who had undergone mastectomies and/or phalloplasty and less than 2% for natal males who had undergone vaginoplasty.<sup>121</sup> However, leaving aside the fact that the studies in this review had high loss to follow-up and/or extremely short follow-up periods, unusually narrow definitions of regret and detransition, and that the review contained an extraordinary number of errors even for a field of research known for sloppy practices, given the high rate of serious complications and the dramatic impact these procedures have on a person’s ability to form intimate relationships, these numbers are suspiciously low.<sup>122</sup>

The case study of one of the earliest participants of the Dutch puberty suppression experiment sheds some light on why this might be. The study describes the natal female’s level of satisfaction and psychological functioning at age 35.<sup>123</sup> The patient did not regret undergoing hormonal and surgical sex-trait modification but reported dealing with significant shame related to her genital appearance,

121 Ibid (n.107)

122 Ibid (n.108)

123 Cohen-Kettenis, P. T., Schagen, S. E., Steensma, T. D., de Vries, A. L., & Delemarre-van de Waal, H. A. “Puberty Suppression in a Gender-Dysphoric Adolescent: A 22-Year Follow-Up.” [In eng]. *Arch Sex Behav* 40, no. 4 (Aug 2011): 843-7. <https://doi.org/10.1007/s10508-011-9758-9>.

experiencing depressive episodes, and having difficulty maintaining long-term relationships. In a previous follow-up study, performed just two years after surgery when the patient was age 20, high levels of satisfaction were recorded, and the female patient was pleased with the outcome of the metoidioplasty.<sup>124</sup> Metoidioplasty is a surgical procedure that involves constructing a small pseudo-penis out of an enlarged clitoris. When a natal female takes testosterone, the clitoris becomes permanently enlarged.

This case study highlights the problem with self-reporting when it comes to regret rates in the field of gender medicine. People who embark on sex-trait modification interventions often sacrifice their health, fertility, sexual function, and healthy body parts in the quest to find peace in their bodies. It's highly probable that, despite experiencing unfavorable outcomes, severe complications, and a clear adverse impact on their ability to establish intimate relationships, many will persist in convincing both themselves and others that their decision was not a mistake. This reluctance to acknowledge regret may stem from a reluctance to confront the consequences of their choices.

Indeed, the early Dutch clinicians were well aware of this possibility. In the first follow-up study of patients who at the time were referred to as transsexuals, conducted approximately 15 years after the Netherlands began offering sex trait modification interventions, the majority of participants reported being happy and feeling no regret despite researchers noting that improvement in “actual life

situations [was] not always observed.”<sup>125</sup> In the 1988 paper, the researchers considered the possibility that in an effort to reduce cognitive dissonance, participants who had undergone hormonal and surgical interventions “simply cannot accept the notion that all has been in vain. The self-reported happiness may have been distorted wishful thinking.”

As already shown, studies that don't rely solely on self-report but instead measure factors such as social functioning and mental health status indicate far less positive outcomes.<sup>126</sup>

When more people regret knee replacement surgery than penis amputation, or more women regret undergoing prophylactic mastectomies for breast cancer risk than gender-affirming mastectomies, these surprising outcomes should raise red flags in a medical organization dedicated to scientific truth.<sup>127,128,129,130</sup> Rather than being proof that sex-trait modification surgeries are the cure for gender distress, these low regret rates are cause for investigation.

### Permanently Medicalizing Transient Identities

Passing the blame onto minors isn't the only way WPATH members minimize the harm done to detransitioners. On November 6, 2021, a medical student responded to a member who shared a 2021 study of detransitioners in the forum, arguing that it was important to emphasize it is “okay for gender and interest in medical options to change over time for each individual,” likening irreversible sex change interventions to tattoos or minor plastic surgeries.<sup>131</sup> The student then went on to suggest

125 Kuiper, B., & Cohen-Kettenis, P. (1988). Sex reassignment surgery: a study of 141 Dutch transsexuals. *Arch Sex Behav*, 17(5), 439-457. <https://doi.org/10.1007/bf01542484>

126 Ibid (n.68)

127 Mahdi, A., Svantesson, M., Wretenberg, P., & Hälleberg-Nyman, M. “Patients’ Experiences of Discontentment One Year after Total Knee Arthroplasty—a Qualitative Study.” [In eng]. *BMC Musculoskelet Disord* 21, no. 1 (Jan 14 2020): 29. <https://doi.org/10.1186/s12891-020-3041-y>.

128 Olson-Kennedy, J., Warus, J., Okonta, V., Belzer, M., & Clark, L. F. “Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults.” *JAMA Pediatrics* 172, no. 5 (2018): 431. <https://doi.org/10.1001/jamapediatrics.2017.5440>.

129 Borgen, P. I., Hill, A. D., Tran, K. N., Van Zee, K. J., Massie, M. J., Payne, D., & Biggs, C. G. “Patient Regrets after Bilateral Prophylactic Mastectomy.” [In eng]. *Ann Surg Oncol* 5, no. 7 (Oct-Nov 1998): 603-6. <https://doi.org/10.1007/bf02303829>.

130 Bruce, L., Khouri, A. N., Bolze, A., Ibarra, M., Richards, B., Khalatbari, S., Blasdel, G., et al. “Long-Term Regret and Satisfaction with Decision Following Gender-Affirming Mastectomy.” *JAMA Surgery* 158, no. 10 (2023): 1070-77. <https://doi.org/10.1001/jamasurg.2023.3352>.

131 Ibid (n.114)

that learning “new things about your gender or what you want from your medical care should be something to be celebrated, and we don’t have to see it as a mistake that was made.”

However, the procedures many of these patients undergo are far more extreme than a tattoo or a nose job. In the replies to the post about the distraught and angry detransitioned 17-year-old, a gynecologist from Barcelona explained she also had a patient wishing to detransition who was seeking vaginoplasty reversal surgery. This procedure involves surgically removing the pseudo-vagina and performing phalloplasty surgery, which is the creation of a non-functional pseudo-penis using skin stripped from the patient’s forearm or thigh.<sup>132,133</sup> It is doubtful any individual would find that cause for celebration.

Many detransitioners feel intense anger and grief regarding the irreversible changes wrought by gender-affirming care. They mourn the loss of their body parts and the experiences, such as bearing children or breastfeeding, that have been taken from them.

An Ontario family physician is the only WPATH member in the files who respects the experience of detransitioners and dares to challenge Bowers and her colleagues on their disrespectful framing of detransition. She told the group her detransitioned patients were all young women who were allowed to change their bodies in permanent ways at a time in their lives when “their physical and sexual identities were in developmental flux.” Most had comorbidities that were not fully addressed and

were rushed into irreversible medical interventions. The physician described this group of patients as being “immersed in their own suffering, loss and grief.”

The fact that a significant number of WPATH members downplay this distressing ordeal by implying that medical professionals did not err in misdiagnosing these youths and subjecting them to unnecessary, invasive procedures serves as proof that WPATH lacks ethical integrity.

In fact, there are members within WPATH who acknowledge that some teenagers are mistaking their emerging homosexuality as a gender identity issue. During the panel, Massey described young patients who, after exploring their sexuality, “got to clarify some of their gender identity issues.”

This is one of the many risks associated with WPATH’s approach to gender medicine. In bypassing exploratory psychotherapy, or indeed just not allowing children to grow and mature but instead immediately placing adolescents on the medical conveyor belt, WPATH-affiliated healthcare providers are inadvertently engaging in a new form of conversion therapy, sterilizing gay and lesbian teens before they have had a chance to understand and accept their sexuality.<sup>134</sup> Data from gender clinics and numerous studies indicate that children and adolescents suffering from gender dysphoria are disproportionately likely to grow up to be homosexual adults, and recent studies of detransitioners likewise show that a significant proportion are also

132 Djordjevic, M. L., Bizic, M. R., Duisin, D., Bouman, M. B., & Buncamper, M. “Reversal Surgery in Regretful Male-to-Female Transsexuals after Sex Reassignment Surgery.” [In eng]. *J Sex Med* 13, no. 6 (Jun 2016): 1000-7. <https://doi.org/10.1016/j.jsxm.2016.02.173>.

133 “Phalloplasty for Gender Affirmation.” Johns Hopkins Medicine, 2023, <https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/phalloplasty-for-gender-affirmation>.

134 “Current Debates.” Gender Identity Development Service, 2023, <https://gids.nhs.uk/gender-identity-and-sexuality/#:~:text=For%20young%20people,males%20or%20females>.



homosexual.<sup>135,136,137,138,139,140</sup>

The unethical and unscientific slant of WPATH is also evident in the way detransition is framed by some within the forum. On November 10, 2021, a research coordinator in the forum suggested that the very idea of detransitioning is “problematic” because it “frames being cisgender as the default and reinforces transness as a pathology.” The young member argued that “it makes more sense to frame gender as something that can shift over time, and figure out ways to support people making the choices they want to make in the moment, with the understanding that feelings around decisions make [sic] change over time.”

However, it raises serious ethical questions when surgeons are tasked with the removal of healthy body parts, especially when such procedures are in pursuit of aligning a young person’s physical form with an identity that is recognized as unstable and as yet unsettled.

Of yet more concern is the possibility that some young people are adopting a transgender identity as a trauma response, and WPATH-affiliated professionals are permanently medicalizing these distressed individuals. In malpractice lawsuits filed by Prisha Mosley and Isabelle Ayala, the trauma of being the victim of sexual assault at a young age is described as a contributing factor in the adoption of a transgender identity. Inside WPATH, members are aware of this possibility, yet still, the group’s official position is immediate affirmation and access to drugs and surgeries if that is what the patient desires.<sup>141</sup> This approach also has opportunity costs, as the focus on gender identity and medical interventions may divert

attention from the essential therapy needed to effectively address and manage the underlying trauma in these young individuals.

In a September 2021 thread in the forum, a counselor noted that “[t]rauma is common among trans clients,” and several replies indicated that others had observed this trend as well. In the panel discussion, Metzger and his colleagues discuss a young person who, like Mosley and Ayala, began identifying as transgender after “an unfortunate, traumatic sexual event.” Massey talks about the hope that the therapists involved could “help the young person distinguish between the assault and their gender identity” but points out the difficulty of this task because “there are times working with young people where they don’t even disclose an assault or some type of sexually coercive or unpleasant experience.”

Massey states that “even good therapists” are going to be limited at times, unable to get everything that’s going on with a child. “Sometimes even adults don’t bring it forward, so it’s a high bar to cross sometimes to try to catch everything that may be affecting somebody’s view of themselves and across domains of their life experiences.”

### WPATH Has Broken the Chain of Trust in Medicine

In medicine, there is a concept called the “chain of trust.”<sup>142,143</sup> Doctors must be able to trust that their professional training is grounded in robust scientific evidence because, given the limited time available to medical professionals, it is not feasible for them to thoroughly investigate every aspect (diagnosis, prognosis,

135 Ibid (n.70)

136 Ibid (n.2)

137 Ibid (n.114)

138 Vandenbussche, E. “Detransition-Related Needs and Support: A Cross-Sectional Online Survey.” *Journal of Homosexuality* 69, no. 9 (2022/07/29 2022): 1602-20. <https://doi.org/10.1080/00918369.2021.1919479>.

139 Drescher, J., & Pula, J. (2014). Ethical issues raised by the treatment of gender-variant prepubescent children. *Hastings Cent Rep*, 44 Suppl 4, S17-22. <https://doi.org/10.1002/hast.365>

140 Cantor, J. M. (2020). Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy. *J Sex Marital Ther*, 46(4), 307-313. <https://doi.org/10.1080/0092623x.2019.1698481>

141 “Active and Resolved Cases.” Campbell Miller Payne, 2023, <https://cmppllc.com/our-cases>, Isabelle Ayala and Prisha Mosley’s Cases.

142 “Heidi Larson, Vaccine Anthropologist.” *The New Yorker*, 2021, <https://www.newyorker.com/science/annals-of-medicine/heidi-larson-vaccine-anthropologist>.

143 Herman, R. (1994). RESEARCH FRAUD BREAKS CHAIN OF TRUST. *The Washington Post*. <https://www.washingtonpost.com/archive/lifestyle/wellness/1994/04/19/research-fraud-breaks-chain-of-trust/ff456e7-b8f7-496e-9b02-6c41c30dfd0a/>

and treatment) of every illness. For medicine to function efficiently, doctors must be confident that those who issue practice guidelines have diligently and rigorously evaluated all the relevant evidence for the safety and efficacy of treatments.<sup>144</sup>

WPATH has broken the chain of trust in gender medicine. WPATH presents itself as scientific but is in fact an advocacy group promoting risky, experimental, and cosmetic procedures in the guise of well-researched and “medically necessary” care. WPATH is held up as the source of all knowledge about gender-affirming care, but the scientific basis for their recommendations is exceptionally weak. The group exists solely to shield doctors from legal liability, through the creation of guidelines it conveniently calls “standards of care,” and to ensure insurance coverage for sex-trait modification procedures.

Due to its outward appearance as a professional medical association, complete with a peer-reviewed journal and bibliography of scientific literature, the wider medical community places its trust in WPATH’s “Standards of Care.” WPATH and its members have also influenced the position statements and practice guidelines of the American Academy of Pediatrics (AAP), the American Psychological Association (APA), and The Endocrine Society.

Further down the chain, parents and vulnerable patients trust the recommendations of their pediatricians, endocrinologists, and mental health professionals—clinicians who are either themselves WPATH-affiliated or who look to their WPATH-influenced professional associations for guidance on how to deal with children who feel distressed about their bodies.

144 O’Malley, S. & Ayad, S. Pioneers Series: We Contain Multitudes with Stephen Levine. Podcast audio. Gender: A Wider Lens Podcast 2022. <https://gender-a-wider-lens.captivate.fm/episode/60-pioneers-series-we-contain-multitudes-with-stephen-levine>, 34:53.



## WPATH HAS NO RESPECT FOR MEDICAL ETHICS

Traditional medical ethics is more than just “first, do no harm.” The guiding principle of Hippocratic medicine is that illness places the afflicted into a compromised state against their will and preference. It is in this compromised state that the person enters into the doctor-patient relationship. Therefore, the patient must be able to trust that their doctor will use his or her knowledge and expertise only for the purpose of healing or ameliorating symptoms and easing suffering, always with the priority of minimizing harm.

Throughout most of medical history, medicine did not involve intentionally destroying a healthy, functioning bodily system. It is only in the 20th century that a new pseudo-medical approach has emerged that views the patient more as a consumer and the doctor as a supplier of pharmaceutical and surgical interventions tasked with fulfilling the patient’s desires, which are quickly defined as needs. In the past, the emphasis on autonomy in medical ethics was meant to act as a shield: there were things a doctor could not do to you without your consent. Nowadays, and especially in gender medicine, autonomy acts as a sword: in its name, there is nothing a doctor may deny you.

The consumer-driven model of autonomy involves giving the patient whatever he or she wants, so long as certain criteria are met: The clinician is technically capable of doing it; the patient wants it for whatever reason; it’s legal, and the patient can pay for it.

This consumer-driven approach to healthcare is the model adopted by WPATH. The world-leading transgender health group advocates for a transition-on-demand style of care, valuing patient autonomy over avoidance of harm. WPATH’s SOC8 more closely

resembles a shopping list of risky and invasive cosmetic interventions, with each chapter concluding that the procedures are medically necessary if the patient so desires.

Such recommendations extend as far as non-binary “nullification” surgeries to create a smooth, sexless appearance or “bi-genital” surgeries involving the creation of a second set of genitals. There is also a chapter on people who identify as eunuchs and seek chemical or surgical castration as a means to affirm their “eunuch identities.” Within the WPATH Files, there are discussions regarding these “non-standard” procedures and how to manage them. However, notably absent from these discussions is any consideration of the ethical concerns surrounding surgeries that destroy healthy reproductive organs in pursuit of creating bespoke anatomical features that do not exist in nature.

### The Ethics of Informed Consent

Informed consent in medicine is the process by which a healthcare provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention. The patient must be competent to make a voluntary decision about whether to undergo the procedure or intervention.<sup>145</sup>

Obtaining informed consent in medicine is a process that should include three primary components: first, the provision of accurate, up-to-date information regarding the nature of the condition, the proposed treatment, and all available alternatives; second, an evaluation of the patient’s understanding, and when applicable, the caregiver’s understanding of the presented information and their ability to make informed medical decisions; and third, obtaining signatures confirming that informed

145 Shah, P., Thornton, I., Turrin, D., & Hipskind, J.E. “Informed Consent.[Updated 2020 Aug 22].” StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing (2021). <https://www.ncbi.nlm.nih.gov/books/NBK430827/#:~:text=Introduction,undergo%20the%20procedure%20or%20intervention.>

consent has been secured.<sup>146,147</sup>

A discussion about *all* potential risks of a treatment, as well as all the uncertainties surrounding the benefits, is an integral part of informed consent. This involves addressing general risks, risks specific to the procedure, possible consequences of not undergoing treatment, and exploring alternative treatment options.

### Minors Cannot Consent to Sex Trait Modification Procedures

WPATH members believe that minors can understand and give cognitive consent to sex-trait modification interventions that could have a life-long impact on their health, fertility, and future sexual function. In the files, the chief medical officer from Texas advised a concerned therapist to allow a troubled 13-year-old girl to begin testosterone therapy; a therapist discussed starting a 10-year-old girl on puberty blockers; WPATH President Bowers openly admitted that natal male children are being left anorgasmic for life; and one surgeon reported performing 20 vaginoplasties on minors.

Minors lack the maturity and cognitive capacity to understand the risks associated with such interventions and the long-term implications for their well-being. Additionally, their limited or nonexistent sexual experiences make it impossible for them to grasp the magnitude of what they are forfeiting. The leaked panel discussion proves that WPATH members know this. Yet, WPATH continues to advocate for placing minors, some as young as nine years old, on this irreversible medical pathway.

As a way to rationalize allowing minors to consent to sex-trait modification treatments, the full effects of which they could not possibly comprehend, some of the Identity Evolution Workshop panelists drew an analogy with treating childhood-onset diabetes.

“When a kid takes diabetic medication, do they have

to understand everything about their pancreas and everything that’s happening?” Berg asked the panel rhetorically. Later, Green said, “If you have a known condition, like diabetes, you don’t have to understand every nuance about what the insulin is going to do to you in order to give informed consent.”

However, the analogy is flawed for several reasons. In order to obtain a diabetes diagnosis, there is a biological test to confirm the illness. The cause is known; the treatment protocol is well-studied; the outcome of treating with insulin is understood, and the risks involved in not treating are clear. Indeed, if left untreated, the illness is fatal. Insulin therapy also does not result in lifelong sterility, nor does it impact a young person’s future sexual function. It is a treatment with solid scientific evidence that the benefits greatly outweigh the risks, making the informed consent process straightforward.

But the same cannot be said for using puberty blockers and cross-sex hormones to help young adolescents manage their discomfort with their sex. There is no diagnostic test to confirm a diagnosis of gender dysphoria; instead, it is based on a young person’s subjective sense of self that is constantly changing and evolving. Likewise, there is no way to predict which children and adolescents will persist in their transgender identities as adults. There is also no good-quality scientific evidence to support the use of puberty blockers as a remedy for this poorly defined disorder, and there are no long-term outcome studies demonstrating that the benefits outweigh the risks; in fact, there is mounting evidence to the contrary.

The combination of puberty blockers and cross-sex hormones could leave a young patient sterile for life, and the drugs come with a host of known and anticipated side effects, including brittle bones, cognitive impairment, and heightened risk of cancer and cardiovascular disease, as well as uncertainty concerning resolution of gender dysphoria.

146 “Informed Consent.” AMA Code of Medical Ethics, <https://code-medical-ethics.ama-assn.org/ethics-opinions/informed-consent>.

147 Katz, A. L., and Webb, S. A. “Informed Consent in Decision-Making in Pediatric Practice.” [In eng]. *Pediatrics* 138, no. 2 (Aug 2016). <https://doi.org/10.1542/peds.2016-1485>.

What's more, all studies from the era of gender medicine pre-dating the puberty suppression experiment show that most children, if not affirmed and socially and medically transitioned, will desist and reconcile with their birth sex during or after puberty.<sup>148</sup> Although there is at present no scientific literature available regarding persistence rates for the recently emerged adolescent-onset cohort, which currently comprises the majority of referrals to pediatric gender clinics, existing knowledge about adolescent development suggests significant uncertainty regarding the stability of this group's transgender identities into adulthood.<sup>149</sup>

That experts within WPATH cannot see the difference between the two treatment protocols is further proof that members of this organization do not have a solid understanding of science.

#### Misinformed Parents Cannot Give Informed Consent

For legal reasons, it falls to parents to sign the consent form for their child's sex-trait modification hormonal and surgical interventions, but WPATH's public and private communications indicate that members are misinforming parents about the experimental treatment protocol.

Parents can only give informed consent if they are told the truth about every stage of the "transition" process, starting with social transition.

Changing names and pronouns is often portrayed as a harmless, non-medical step to alleviate a child's distress. It is sold to parents as completely reversible at any time, but all available evidence suggests the contrary.

Social transition has a powerful iatrogenic effect, meaning affirming a child's transgender identity and allowing a change of name and pronouns serves to concretize the identity in the young person's mind, making desistance far less likely. Historically, in the absence of social transition, the majority of gender dysphoric children would naturally desist and reconcile with their birth sex during or after puberty.<sup>150,151,152</sup> Most would come out as gay.

In her interim report for the independent review of England's youth gender service, Dr. Hilary Cass noted this iatrogenic effect, stating that social transition is not a "neutral act" but rather "it is important to view it as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning."<sup>153</sup>

However, in March 2023, WPATH made a public statement in response to Missouri Attorney General Andrew Bailey's emergency regulation banning sex-trait modification for minors, citing a July 2022 article published by the American Academy of Pediatrics. The paper by Dr. Kristina R. Olson et al. showed five years after their initial social transition, 97.5% of youth who identify as transgender continued to do so.<sup>154,155</sup> This article, WPATH appears to believe, is evidence that these young people are truly transgender and, therefore, deserving of medical treatment. In truth, what it shows is that social transition serves to lock in the transgender identity.

While it is not necessary to sign a consent form before

148 Cantor, J. M. (2016). Do trans- kids stay trans- when they grow up? [http://www.sexologytoday.org/2016/01/do-trans-kids-stay-trans-when-they-grow\\_99.html](http://www.sexologytoday.org/2016/01/do-trans-kids-stay-trans-when-they-grow_99.html)

149 Ibid (n.49); Ibid (n.50)

150 Ibid (n.2)

151 Ibid (n.3)

152 Kaltiala-Heino, R., Bergman, H., Työläjäarvi, M., & Frisén, L., "Gender Dysphoria in Adolescence: Current Perspectives." [In eng]. *Adolesc Health Med Ther* 9 (2018): 31-41. <https://doi.org/10.2147/ahmt.S135432>.

153 "The Cass Review: Independent Review of Gender Identity Services for Children and Young People: Interim Report." 2022, 62. <https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim-Report-Final-Web-Accessible.pdf>.

154 WPATH. (2023). USPATH and WPATH Confirm Gender-Affirming Health Care is Not Experimental; Condemns Legislation Asserting Otherwise. WPATH. [https://www.wpath.org/media/cms/Documents/Public%20Policies/2023/USPATH\\_WPATH%20Response%20to%20AG%20Bailey%20Emergency%20Regulation%2003.22.2023.pdf](https://www.wpath.org/media/cms/Documents/Public%20Policies/2023/USPATH_WPATH%20Response%20to%20AG%20Bailey%20Emergency%20Regulation%2003.22.2023.pdf)

155 Olson, K. R., Durwood, L., Horton, R., Gallagher, N. M., & Devor, A. (2022). Gender Identity 5 Years After Social Transition. *Pediatrics*, 150(2). <https://doi.org/10.1542/peds.2021-056082>

a minor socially transitions, if WPATH members are failing to warn parents of the iatrogenic effect of social transition, the parents' decision is not an informed one.

The next step of the transition pathway for a minor is puberty blockers, and again, there is evidence that WPATH members are not providing parents with the most up-to-date information about this intervention. In January 2022, Bowers described puberty blockers as “fully reversible” despite the fact that by this point, there was abundant evidence to the contrary.

In fact, very early in the puberty suppression experiment, it was noted that almost every adolescent who commences puberty blockers proceeded to cross-sex hormones, when historical data showed that most children would cease to identify as members of the opposite sex after puberty.<sup>156, 157, 158</sup> This means that puberty suppression is almost certainly the first step in a longer treatment protocol, not a mere “window of time” for the adolescent to think about his or her identity. Therefore, it cannot be called “fully reversible.”

Massey's comments in the May 2022 panel discussion prove that people within WPATH understand this. The WPATH therapist stressed the importance of discussing “fertility preservation” with youth who are going on puberty blockers because many of those youth will go directly onto affirming hormone therapies that will eliminate the development of their gonads producing sperm or eggs.”

Clinicians and researchers have long recognized that

the cognitive development that occurs as a result of endogenous puberty is the remedy for childhood gender dysphoria. This was noted by the Dutch clinicians who pioneered puberty suppression and who also happen to be members of WPATH. Blocking puberty, therefore, means blocking the natural cure to gender dysphoria.

Metzger's comments during the panel indicate that, privately, WPATH members understand this negative impact of freezing adolescents in a child-like state. When Metzger spoke about “robbing these kids of that sort of early to mid pubertal sexual stuff that's happening with their cisgender peers,” he was referring to robbing children of the same developmental process that would almost certainly have enabled them to overcome their dysphoria naturally.

Therefore, any WPATH-affiliated healthcare professional who tells parents that puberty blockers are “fully reversible” is providing inaccurate information and consequently failing to obtain proper informed consent.

Furthermore, true informed consent can only be obtained if the healthcare provider informs parents that the evidence base for the life-altering interventions of puberty suppression, cross-sex hormones, and surgeries is low quality, as has been found by every systematic review to date;<sup>159, 160, 161, 162</sup> and that other countries that once offered gender-affirming care have since drastically scaled back the practice due to concerns about iatrogenic harm. These parents must also understand the often debilitating side effects and long-term serious health risks of cross-sex

156 Ibid (n.2)

157 Delemarre-van de Waal, H. A., & Cohen-Kettenis, P. T. “Clinical Management of Gender Identity Disorder in Adolescents: A Protocol on Psychological and Paediatric Endocrinology Aspects” This Paper Was Presented at the 4th Ferring Pharmaceuticals International Paediatric Endocrinology Symposium, Paris (2006). Ferring Pharmaceuticals Has Supported the Publication of These Proceedings.” *European Journal of Endocrinology* 155, no. Supplement\_1 (2006): S131-S137. <https://doi.org/10.1530/eje.1.02231>. <https://doi.org/10.1530/eje.1.02231>.

158 Carmichael, P., Butler, G., Masic, U., Cole, T. J., De Stavola, B. L., Davidson, S., Skageberg, E. M., Khadr, S., & Viner, R. M. “Short-Term Outcomes of Pubertal Suppression in a Selected Cohort of 12 to 15 Year Old Young People with Persistent Gender Dysphoria in the UK.” *PLOS ONE* 16, no. 2 (2021): e0243894. <https://doi.org/10.1371/journal.pone.0243894>. <https://dx.doi.org/10.1371/journal.pone.0243894>.

159 Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., Rosenthal, S. M., et al. “Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline.” [In eng]. *J Clin Endocrinol Metab* 102, no. 11 (Nov 1 2017): 3869-903. <https://doi.org/10.1210/je.2017-01658>.

160 “Nice Evidence Reviews.” The Cass Review, <https://cass.independent-review.uk/nice-evidence-reviews/>.

161 “Hormonbehandling Vid Könnsdysfori - Barn Och Unga.” SBU UTVÄRDERAR, 2022, [https://www.sbu.se/contentassets/ea4e698fa0c4449aaac964c5197cf940/hormonbehandling-vid-konnsdysfori\\_barn-och-unga.pdf](https://www.sbu.se/contentassets/ea4e698fa0c4449aaac964c5197cf940/hormonbehandling-vid-konnsdysfori_barn-och-unga.pdf).

162 “One Year since Finland Broke with Wpath “Standards of Care.” Society for Evidence Based Gender Medicine, 2021, [https://segm.org/Finland\\_deviates\\_from\\_WPATH\\_prioritizing\\_psychotherapy\\_no\\_surgery\\_for\\_minors](https://segm.org/Finland_deviates_from_WPATH_prioritizing_psychotherapy_no_surgery_for_minors).

hormones before the consent form is signed.

Lastly, many parents are told inaccurate suicide statistics. They are informed that if they don't consent to their child undergoing experimental sex-trait modification, there exists a substantial risk of suicide. The ultimatum, "You can either have a living son or a dead daughter?" is put to parents in gender clinics all over North America.<sup>163,164,165</sup> This constitutes coercion, emotional blackmail, and medical malpractice. Rather than proper informed consent, it is misinformed consent obtained under duress.

### The Transition-or-Suicide Myth

WPATH members, and gender-affirming clinicians in general, often frame sex trait modification as "life-saving" care and assert that without it, transgender-identified youth and adults are at high risk of suicide.

Many trans activists perpetuate this transition-or-suicide narrative. "Gender-affirming care is medical care. It is mental health care. It is suicide prevention care. It improves quality of life, and it saves lives," said Admiral Rachel Levine during a 2022 speech in Texas.<sup>166</sup> "Fifty percent of transgender youth attempt suicide before they are age 21," claimed Jeannette Jennings, mother of transgender reality TV star Jazz, in a 2016 interview published in the American Academy of Pediatrics (AAP) journal.<sup>167</sup>

But how much truth is there to the claim that gender-affirming care is "suicide prevention care"? The answer is

very little. It's important to distinguish the difference between suicide ideation (or thoughts), suicide attempts, and completed suicides. The term "suicidality" is often used to refer to all three phenomena despite the important differences between them. For example, middle-aged men are at higher risk of death by suicide than adolescents of both sexes, but adolescent girls and young women exhibit the highest rates of non-lethal suicidal gestures, which could be better interpreted as cries for help.

As indicated in surveys, transgender-identified youth are at elevated risk for suicidality and suicide.<sup>168</sup> Crucially, however, completed suicide in this population is extremely rare, and elevated suicidality is most likely because of comorbid psychopathology, which is extremely common and independently linked to suicidal ideation and behavior. In short, there is no suicide epidemic striking transgender-identified youth, and the claim that "gender" is the cause of and solution to this group's suicidal tendencies is a classic mistaking of correlation for causation.<sup>169</sup>

Research showing a higher rate of suicidality among trans-identified young people usually compares the transgender cohort to the general adolescent population who have no mental health issues. When trans-identified youth are compared to adolescents with similar mental health problems, there is little difference in suicidality.<sup>170</sup>

As well, the elevated suicide risk exists at all stages of the transition process. During a two-year study funded by the National Institutes of Health (NIH) of 315 American youth undergoing "gender-affirming hormone therapy," there were two completed suicides, and 11 youth reported

163 "Affidavit of Jamie Reed." 11. <https://ago.mo.gov/wp-content/uploads/2-07-2023-reed-affidavit-signed.pdf>.

164 "Chloe Cole V. Kaiser Permanente." Dhillon Law Group, 2023, <https://www.dhillonlaw.com/lawsuits/chloe-cole-v-kaiser-permanente/>.

165 "Active and Resolved Cases: Ayala V. American Academy of Pediatrics." Campbell Miller Payne, 2023, 26. <https://cmppllc.com/our-cases>.

166 "Remarks by Hhs Assistant Secretary for Health Adm Rachel Levine for the 2022 out for Health Conference." U.S. Department of Health and Human Services, 2022, <https://www.hhs.gov/about/news/2022/04/30/remarks-by-hhs-assistant-secretary-for-health-adm-rachel-levine-for-the-2022-out-for-health-conference.html>.

167 "Trans Teen Shares Her Story." Pediatrics in Review, 2016, <https://publications.aap.org/pediatricsinreview/article-abstract/37/3/99/34959/Trans-Teen-Shares-Her-Story?redirectedFrom=fulltext?autologincheck=redirected>.

168 Toomey, R. B., Syvertsen, A. K., & Shramko, M. "Transgender Adolescent Suicide Behavior." [In eng]. Pediatrics 142, no. 4 (Oct 2018). <https://doi.org/10.1542/peds.2017-4218>.

169 Biggs, M. "Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom." [In eng]. Arch Sex Behav 51, no. 2 (Feb 2022): 685-90. <https://doi.org/10.1007/s10508-022-02287-7>.

170 de Graaf, N. M., Steensma, T. D., Carmichael, P., VanderLaan, D. P., Aitken, M., Cohen-Kettenis, P. T., de Vries, A. L. C., et al. "Suicidality in Clinic-Referred Transgender Adolescents." [In eng]. Eur Child Adolesc Psychiatry 31, no. 1 (Jan 2022): 67-83. <https://doi.org/10.1007/s00787-020-01663-9>.

considering suicide.<sup>171</sup> These deaths are all the more striking, considering that the researchers screened participants for suicidality. Despite these tragic outcomes, the authors, many of whom are considered some of WPATH's most prominent members, concluded that gender-affirming hormones "improved appearance congruence and psychosocial functioning." In the UK, one study showed four completed suicides, representing 0.03% of youth referred to the Gender Identity Development Service (GIDS) between 2010 and 2020. Two out of the four patients were already in the care of the service, and two were on the waiting list.<sup>172</sup>

What's more, we know that autism,<sup>173</sup> eating disorders,<sup>174</sup> and other mental health issues<sup>175</sup> result in elevated suicide risk for young people. We also know that many adolescents who identify as transgender disproportionately suffer from these very same psychiatric comorbidities and, in many cases, the other mental health issues started long before the teen announced a transgender identity.<sup>176</sup> It is, therefore, theoretically possible that youth already at an elevated risk of suicide and suicidality are drawn to identify as transgender because they see medical transition as a solution to their mental distress, as several detransitioned testimonies indicate.<sup>177,178,179</sup> In such a scenario, sex-trait modification interventions would do nothing to reduce or eliminate suicide risk and, in fact, in the long run, may

increase the risk if the young, mentally unwell person comes to regret undergoing hormonal and surgical procedures.

There is also concern from some experts that many cases of adolescent-onset gender dysphoria are actually cases of borderline personality disorder (BPD). Symptoms of BPD include "identity disturbance" and "recurrent suicidal behavior, gestures, or threats, or self-mutilating behaviour."<sup>180</sup> According to Canadian sexologist James Cantor, "BPD begins to manifest in adolescence, is three times more common in biological females than males, and occurs in 2–3% of the population." Therefore, Cantor argues, "if even only a portion of people with BPD experienced an identity disturbance that focused on gender identity and were mistaken for transgender, they could easily overwhelm the number of genuine cases of gender dysphoria."<sup>181</sup>

In such cases, misdiagnosing BPD as adolescent-onset gender dysphoria and allowing the young person to undergo hormonal and surgical interventions would do nothing to reduce suicidal behavior and could, in fact, lead to a worsening of such behavior. Indeed, a malpractice lawsuit filed by a detransitioned young woman by the name of Prisha Mosley alleges that her BPD was ignored. Instead, her healthcare team convinced her that sex-trait modification interventions would resolve her severe mental

- 171 Chen, D., Berona, J., Chan, Y., Ehrensaft, D., Garofalo, R., Hidalgo, M. A., Rosenthal, S. M., Tishelman, A. C., & Olson-Kennedy, J. "Psychosocial Functioning in Transgender Youth after 2 Years of Hormones." *New England Journal of Medicine* 388, no. 3 (2023): 240-50. <https://doi.org/10.1056/nejmoa2206297>.
- 172 Biggs, M. (2022). Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom. *Arch Sex Behav*, 51(2), 685-690. <https://doi.org/10.1007/s10508-022-02287-7>
- 173 O'Halloran, L., Coey, P., & Wilson, C. "Suicidality in Autistic Youth: A Systematic Review and Meta-Analysis." *Clinical Psychology Review* 93 (2022/04/01/ 2022): 102144. <https://www.sciencedirect.com/science/article/pii/S0272735822000290>.
- 174 Smith, A. R., Zuromski, K. L., & Dodd, D. R. "Eating Disorders and Suicidality: What We Know, What We Don't Know, and Suggestions for Future Research." [In eng]. *Curr Opin Psychol* 22 (Aug 2018): 63-67. <https://doi.org/10.1016/j.copsyc.2017.08.023>.
- 175 Galaif, E. R., Sussman, S., Newcomb, M. D., & Locke, T. F. "Suicidality, Depression, and Alcohol Use among Adolescents: A Review of Empirical Findings." [In eng]. *Int J Adolesc Med Health* 19, no. 1 (Jan-Mar 2007): 27-35. <https://doi.org/10.1515/ijamh.2007.19.1.27>.
- 176 Diaz, S., and Bailey, J. M. "Retracted Article: Rapid Onset Gender Dysphoria: Parent Reports on 1655 Possible Cases." *Archives of Sexual Behavior* 52, no. 3 (2023): 1031-43. <https://doi.org/10.1007/s10508-023-02576-9>.
- 177 Ibid (n.141)
- 178 "Luka Hein V. Unmc Physicians." Liberty Center, <https://libertycenter.org/cases/hein-v-unmc/>.
- 179 "Kiefel First Amendment Complaint", 2022, <https://static1.squarespace.com/static/5f232ea74d8342386a7ebc52/t/63a0afdc02f9322762974cf/1671475168006/Kiefel+First+Amended+Complaint+%28file+stamped%29.pdf>.
- 180 Biskin, R. S., & Paris, J. (2012). Diagnosing borderline personality disorder. *Cmaj*, 184(16), 1789-1794. <https://doi.org/10.1503/cmaj.090618>
- 181 "The Science of Gender Dysphoria and Transsexualism." 2022: 22. [https://ahca.myflorida.com/content/download/4865/file/AHCA\\_GAPMS\\_June\\_2022\\_Attachment\\_D.pdf](https://ahca.myflorida.com/content/download/4865/file/AHCA_GAPMS_June_2022_Attachment_D.pdf).



distress. Her lawyers allege that this “substantially and permanently compounded Prisha’s physical suffering and mental anguish.”<sup>182</sup>

In a small study of 28 Canadian detransitioners, two participants had a co-existing BPD diagnosis, with one young woman expressing frustration that her BPD was only diagnosed after she had undergone a bilateral mastectomy and her mental health deteriorated.<sup>183</sup> Another detransitioned woman from Canada who has filed a malpractice lawsuit against her healthcare team also received a BPD diagnosis years after being misdiagnosed as transgender and undergoing hormonal and surgical sex trait modification interventions.<sup>184</sup>

Thus, the transition-or-suicide narrative is, as Finland’s leading expert on pediatric gender medicine has put it, “purposeful disinformation,” the spreading of which is “irresponsible.”<sup>185</sup> Using suicide threats to influence parents in their decisions over healthcare for their children is a violation of medical ethics and amounts to malpractice. It also makes the false promise that these experimental interventions will eliminate the risk of suicide for the young person when no evidence exists to support such a claim.

As previously mentioned, the few long-term follow-up studies of the adult transgender population also do not indicate that sex-trait modification interventions eliminate or greatly reduce the risk of suicide. A Swedish study<sup>186</sup> of 324 individuals who had undergone genital surgery

between 1973 and 2003 revealed rates of completed suicide post-surgical transition to be greatly elevated over the general population, with trans-identified natal females 40 times more likely to die by suicide and trans-identified natal males 19 times more likely.<sup>187,188</sup>

The largest study conducted to date on the 8,263 patients who passed through the gender clinic in Amsterdam from 1972 to 2017 found that both male and female transgender people had a quadruple rate of suicide and concluded that “the suicide risk in transgender people is higher than in the general population and seems to occur during every stage of transitioning.”<sup>189</sup>

A recent long-term Danish study concluded that people who have undergone sex-trait modification interventions in Denmark have a 3.5 times increased rate of completed suicide post “transition” compared to the general population and 7.7 times the rate of suicide attempts.<sup>190</sup> Another long-term Dutch study found male-to-female transsexuals had a sixfold increased risk of suicide after undergoing sex-trait modification procedures.<sup>191</sup>

Therefore, the sex-trait modification experiment advocated for by WPATH cannot be considered “harm reduction” or “life-saving,” and it is unethical for any medical or mental health professional to assert otherwise. It is also unethical to offer minors and adults with severe mental illness harmful, irreversible medical interventions without first attempting to address their psychiatric

182 “Active and Resolved Cases: Mosely V. Emerson, Et Al.” Campbell Miller Payne, 2023, 2. <https://cmppllc.com/our-cases>.

183 Ibid (n.115)

184 Humphreys, A. (2023). Ontario detransitioner who had breasts and womb removed sues doctors. National Post. <https://nationalpost.com/news/canada/michelle-zacchigna-ontario-detransitioner-sues-doctors>

185 Mutanen, A. (2023). A professor who treats adolescent gender anxiety says no to minors’ legal gender correction. Helsingin Sanomat. <https://www.hs.fi/tiede/art-2000009348478.html>

186 Ibid (n.66)

187 Ibid (n. 186)

188 Levine, S. B., Abbruzzese, E., & Mason, J. W. “Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults.” *Journal of Sex & Marital Therapy* 48, no. 7 (2022): 706-27. <https://doi.org/10.1080/0092623x.2022.2046221>.

189 Wiepjes, C. M., den Heijer, M., Bremmer, M. A., Nota, N. M., de Blok, C. J. M., Coumou, B. J. G., & Steensma, T. D. “Trends in Suicide Death Risk in Transgender People: Results from the Amsterdam Cohort of Gender Dysphoria Study (1972-2017).” [In eng]. *Acta Psychiatr Scand* 141, no. 6 (Jun 2020): 486-91. <https://doi.org/10.1111/acps.13164>.

190 Erlangsen, A., Jacobsen, A. L., Ranning, A., Delamare, A. L., Nordentoft, M., & Frisch, M. “Transgender Identity and Suicide Attempts and Mortality in Denmark.” *JAMA* 329, no. 24 (2023): 2145-53. <https://doi.org/10.1001/jama.2023.8627>.

191 Asscheman, H., Giltay, E. J., Megens, J. A., de Ronde, W. P., van Trotsenburg, M. A., & Gooren, L. J. “A Long-Term Follow-up Study of Mortality in Transsexuals Receiving Treatment with Cross-Sex Hormones.” [In eng]. *Eur J Endocrinol* 164, no. 4 (Apr 2011): 635-42. <https://doi.org/10.1530/eje-10-1038>.



problems through less invasive means.

### Allowing Severely Mentally Ill Patients to Consent to Life-Altering Medical Interventions

Some patients discussed in the files do not appear to have been in a state of sound mind when deciding to undergo sex-trait modification procedures, meaning that it is doubtful that they would have been able to weigh the long-term impact on their future health and sexual function.

Several message threads suggest that WPATH members are allowing mentally unstable people to consent to hormones and surgeries. In an undated post, a nurse practitioner from Halifax, NS, described a patient with very complex mental health issues, including PTSD, major depressive disorder (MDD), observed dissociations, and schizoid typical traits. The nurse told the group that the patient is eager to start hormones, but psychiatry is recommending holding off.

“My practice is based fully on the informed consent model however this case has me perplexed; struggling internally as to what is the right thing to do,” said the nurse.

Dr. Dan Karasic of the University of California San Francisco (UCSF), the lead author of the mental health chapter of WPATH’s SOC8, was baffled by the nurse’s perplexity. “I’m missing why you are perplexed,” said Karasic. “The mere presence of psychiatric illness should not block a person’s ability to start hormones if they have persistent gender dysphoria, capacity to consent, and the benefits of starting hormones outweigh the risks.”

While Karasic is correct that the mere presence of mental illness does not automatically mean a patient is incapable of consenting to a medical procedure, it is questionable that a patient in such a state could rationally weigh up the long-term implications of irreversible cross-sex hormones. Also, given the aforementioned negative

impact of these hormones on a patient’s sexual function, it is doubtful that the benefits outweigh the risks, even in a healthy individual. People suffering from mental illness often struggle to form long-term romantic relationships. Hormone therapy places an enormous medical burden on the body and impairs sexual function, making life more difficult for a mentally ill person already struggling.

However, in the files, Karasic’s opinion enjoys the support of his fellow members, with the aforementioned California therapist reporting having patients with DID, MDD, bipolar, and schizophrenia that “do just fine on HRT” and an orchiectomy making a “huge difference” to the life of a homeless person. An orchiectomy is the surgical removal of the testes. But again, without long-term follow-up, it is impossible to know if these claims of success are accurate.

There are other therapists in the WPATH Files discussing patients suffering from dissociative identity disorder (DID), formerly known as multiple personality disorder (MPD), being allowed to consent to sex-trait modification procedures. The MPD epidemic of the 1980s and 1990s was iatrogenic in nature, meaning it was created and spread by misguided therapists. After the scandal collapsed under the weight of lawsuits, MPD was rebranded as DID, and as a diagnosis, its occurrence decreased significantly. However, there has been a recent resurgence, with TikTok providing an important vector for the contagion and certain WPATH members embracing DID “alter” identities as deserving of affirmation along with transgender identities.<sup>192</sup>

In 2017, Karasic gave a presentation at the conference of WPATH’s US branch, USPATH, about the importance of affirming “plural” identities.<sup>193</sup> During the presentation, the prominent WPATH psychiatrist detailed case studies of patients with DID who had undergone hormonal and/or surgical sex trait modification interventions.

One patient was a male who identified as

<sup>192</sup> #dissociativeidentitydisorder. (2024). TikTok. <https://www.tiktok.com/tag/dissociativeidentitydisorder?lang=en>

<sup>193</sup> Not plural-phobic: USPATH psychiatrist promotes transition for multiple personalities. (2017). 4thWaveNow. <https://4thwavenow.com/2017/12/29/not-plural-phobic-uspath-psychiatrist-promotes-transition-for-multiple-personalities/>

“genderqueer” and underwent “flat front” nullification surgery, or the amputation of the genitals to create a smooth, sexless appearance. This male suffered from bipolar disorder and “alcohol use disorder” and was treated with spironolactone, an anti-androgen hormone blocker, followed by estradiol, or synthetic estrogen. Karasic reported that the patient had seven alters, two of which were “agender” and one female. “Alters were in agreement about surgery,” Karasic assured the audience.

Another DID patient was a 27-year-old male who identified as a “genderqueer system.” A system is multiple distinct personalities sharing one body. This particular patient, who was diagnosed with autism in childhood, had 85 “headmates,” with the primary “front” alter being female. The patient was on estradiol along with a drug to prevent breast growth and had undergone an orchiectomy at age 25.

Karasic told the audience he had had several patients who identified as trans and plural, which he put down to his reputation “as a psychiatrist who was not plural phobic.” This is the caliber of expert WPATH felt appropriate to appoint as the lead author of its SOC8 mental health chapter.

At WPATH’s 2022 International Symposium in Montreal, a team of researchers presented the preliminary findings of their research into the confluence of transgender and “plural” identities.<sup>194</sup> The team grappled with the complexity of obtaining informed consent for sex-trait modification hormones and surgeries from patients with hundreds of alters, many with differing gender identities. Their research quoted an individual called The Redwoods, who identifies as nine separate people sharing a “trans body,” explaining the difficulties faced by patients who were forced to choose between their gender dysphoria diagnosis and their DID diagnosis “because providers wrongly believed you could not be both.”

The research team drew few solid conclusions but

recommended affirmation of both trans and plural identities, which could lead to “gender and plural euphoria,” as well as the suggestion that plurals have their separate personalities use an app to talk to each other to reach an agreement about hormonal and surgical sex trait modification interventions. The lead researcher appears in the WPATH Files in a thread dated September 2021, discussing the “robust community developing of people who identify as plural” as well as “plural positivity” conferences. He stated there was a “general consensus that mental health and medical providers need more training on this topic so they can provide affirming care.”

Inside the WPATH forum, members grapple with how to manage “trans clients” with DID when “not all the alters have the same gender identity,” with one North Carolina psychologist stressing that it was “imperative to get all the alters who would be affected by HRT to be aware and consent to the changes.”

“Ethically, if you do not get consent from all alters you have not really received consent and you may be open to being sued later, if they decide HRT or surgery was not in their best interest,” said the psychologist. This reply was one of only two mentions of ethics in the whole WPATH Files.

Another therapist admitted lying about her patients’ diagnosis of DID in referral letters, calling it “complicated PTSD” instead because she didn’t “think surgeons would blink at that as much as DID.” But she also confessed that two patients with DID whom she had referred for hormones now experience regret and feel that “their decision to start hormones was colored by trauma and DID and now, after more therapy and understanding, wish they had dug deeper before starting hormones.”

These two cases of regret demonstrate how WPATH’s approach of prioritizing “gender” and bypassing exploratory psychotherapy that seeks to uncover the origins of distress risks setting patients up for iatrogenic harm and later regret.

McGinn, the aforementioned surgeon who has

194 Wolf-Gould, C., Flynn, S., McKie, S. (2022, September 16-20). An Exploration of Transgender and Plural Experiences [Conference presentation].

performed 20 vaginoplasties on minors, joined the discussion to report performing two “vulvovaginoplasty” surgeries and one bilateral mastectomy on patients suffering from DID and happily stated that all three “did ok out to the six-month mark.”

However, once again, a follow-up period of six months is not long enough to declare the surgeries a success. In the short term, there may be misleading signs of improved mental well-being, but how will the patient, particularly one who consented while in a state of severe mental instability, feel about their genital surgery or bilateral mastectomy in 10, 20, or 30 years? Gender-affirming healthcare providers never seem to ask this vital question and yet claim to be providing ethical medical care.

A Virginia doctor in the forum was of the opinion that as long as persistent gender dysphoria is present, those with severe mental health issues such as bipolar disorder, autism, and schizoaffective disorder should be allowed to consent to vaginoplasty. “It would be great if every patient could be perfectly cleared prior to every surgical intervention, but at the end of the day it is a risk/benefit decision,” she said, shrugging off the possibility that the severely mentally unwell patients may be unable to cope with the grueling dilation schedule and may suffer serious complications as a result.

In fact, within all the files, the sole instance where WPATH members express concern regarding the potential dangers and adverse effects of a medical procedure is found in a conversation involving a trans-identified natal male interested in hormone-induced lactation purely for the sake of experiencing it, with no intention of nursing an infant. From the information given, the patient appears to be otherwise mentally well, but his doctor described having ethical issues with this request, as it was not without some risk.

The replies echoed the doctor’s concerns, with one doctor calling the request unethical because it was a “medical intervention that is not necessary” and a San Francisco ethicist calling the reason for the intervention “questionable.” The ethicist reminded the doctor that he is

a professional “to whom society gives certain privileges” in exchange for his “prudent use of resources” and his “commitment to interventions where benefits outweigh risk and to ‘at least do no harm.’”

“I understand your patient’s desire to experience lactation as one function of her womanhood,” continued the ethicist. “But that is [an] insufficient reason, in my estimation, to intervene medically.” While this expert in medical ethics is not required to comment on every post within the forum, it is telling that she does not appear in any of the discussions regarding allowing people with severe mental illness to consent to vaginoplasty or threads concerning the creation of second sets of genitals for people who identify as non-binary, reminding WPATH surgeons to do no harm. Nor does she comment in message threads about drastic hormone interventions for minors that will leave them anorgasmic for life, reminding WPATH doctors that benefits must outweigh risks. By comparison, the male’s request to induce lactation just to experience it is trivial.

Notably, all the WPATH members in the discussion avoid tackling the uncomfortable truth about the patient’s motivation. The man being discussed in the forum may fit the description of having physiologic autogynephilia, meaning his desire to lactate may have been for erotic purposes.

Contrast how members talk about the natal male wishing to use drugs to induce lactation with the discussion about a 13-year-old girl who identified as non-binary and wished to begin taking testosterone. Her therapist was worried that 13 was too young and also mentioned a “possible complication,” which was that “there is some purposeful malnutrition and restrictive eating for a more non-binary appearance.”

But instead of recommending addressing the eating disorder and general mental health issues before starting the distressed teenager on such a powerful hormone, or indeed questioning the ethics of allowing an obviously troubled girl to consent to the irreversible effects of testosterone, a pediatric endocrinologist informed the

therapist that WPATH has removed all the minimum age requirements in its latest standards of care. Then, a chief medical officer of a health center in Texas cautioned that “waiting appears to increase the rate of suicide” because the patient would have to deal with “menstrual periods and complete breast development.” The expert in medical ethics is conspicuously absent from the discussion.

### Minority Stress

WPATH’s belief system has a built-in answer to the problem of high rates of psychiatric comorbidities before and after transition as well as post-transition suicides. That answer is the minority stress model. According to WPATH, the mental health issues experienced by members of the transgender community before, during, and after sex-trait modification interventions are the result of living in a transphobic society, in other words, the stress of being a member of an oppressed minority.<sup>195</sup> Research produced by some WPATH members claims that gender-affirming care can resolve psychiatric comorbidities such as depression, anxiety, suicidality, or even autism.<sup>196,197,198</sup>

The minority stress hypothesis, borrowed from the gay rights movement, has never been empirically verified in the context of transgender medicine, but it serves as a way for gender-affirming healthcare providers to deny culpability when a person regrets their transition or when the transition doesn’t improve their mental health.<sup>199</sup> It enables

these doctors to blame society for being intolerant, rather than themselves for allowing a minor or a mentally unstable adult to undergo drastic, life-altering medical interventions. As well, because “intolerance” is defined by the activist clinician-researchers themselves in ever more implausible ways, minority stress is essentially an unfalsifiable and, thus, unscientific theory. It is thus also an all-too-convenient insurance policy for gender clinicians against malpractice allegations.

In fact, Sweden serves as a counter-argument to the minority stress model. As a highly tolerant nation, if the minority stress model were correct, we would expect to see far lower rates of mental illness and suicidal behavior among the transgender population, but the opposite is true. The long-term Swedish study found post-op transgender adults had a significantly elevated risk of suicide as well as increasing mortality rates.<sup>200</sup>

### Realistic Expectations

Numerous studies indicate that many adolescents experiencing adolescent-onset gender dysphoria suffer from multiple psychiatric comorbidities that pre-date the onset of distress about their sex.<sup>201,202,203,204</sup> Detransitioner testimony supports the hypothesis that some mentally distressed people could be drawn to self-diagnosing as transgender after being led to believe that sex-trait modification procedures are a miracle cure for all their

195 Meyer, I. H., Russell, S. T., Hammack, P. L., Frost, D. M., & Wilson, B. D. M. “Minority Stress, Distress, and Suicide Attempts in Three Cohorts of Sexual Minority Adults: A U.S. Probability Sample.” *PLOS ONE* 16, no. 3 (2021): e0246827. <https://doi.org/10.1371/journal.pone.0246827>.

196 Turban, J. L. “Potentially Reversible Social Deficits among Transgender Youth.” [In eng]. *J Autism Dev Disord* 48, no. 12 (Dec 2018): 4007-09. <https://doi.org/10.1007/s10803-018-3603-0>.

197 Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. “Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation.” [In eng]. *Pediatrics* 145, no. 2 (Feb 2020). <https://doi.org/10.1542/peds.2019-1725>.

198 Turban, J. L., & van Schalkwyk, G. I. ““Gender Dysphoria” and Autism Spectrum Disorder: Is the Link Real?” [In eng]. *J Am Acad Child Adolesc Psychiatry* 57, no. 1 (Jan 2018): 8-9.e2. <https://doi.org/10.1016/j.jaac.2017.08.017>.

199 Mayer, L. S., and McHugh, P. R. “Part Two: Sexuality, Mental Health Outcomes, and Social Stress.” *Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences*, *The New Atlantis* 50 (2016): 73-75. <https://www.thenewatlantis.com/publications/part-two-sexuality-mental-health-outcomes-and-social-stress-sexuality-and-gender>.

200 Ibid (n.66)

201 Kaltiala-Heino, R., Sumia, M., Työläjärvi, M., & Lindberg, N. “Two Years of Gender Identity Service for Minors: Overrepresentation of Natal Girls with Severe Problems in Adolescent Development.” [In eng]. *Child Adolesc Psychiatry Ment Health* 9 (2015): 9. <https://doi.org/10.1186/s13034-015-0042-y>.

202 Bechard, M., VanderLaan, D. P., Wood, H., Wasserman, L., & Zucker, K. J. “Psychosocial and Psychological Vulnerability in Adolescents with Gender Dysphoria: A “Proof of Principle” Study.” [In eng]. *J Sex Marital Ther* 43, no. 7 (Oct 3 2017): 678-88. <https://doi.org/10.1080/0092623x.2016.1232325>.

203 Kozłowska, K., Chudleigh, C., McClure, G., Maguire, A. M., & Ambler, G. R. “Attachment Patterns in Children and Adolescents with Gender Dysphoria.” *Frontiers in psychology* (2021): 3620. <https://www.frontiersin.org/articles/10.3389/fpsyg.2020.582688/full>.

204 Ibid (n.176)

psychological suffering.<sup>205</sup>

In the files, there is evidence that WPATH members encourage such false hopes. A Montana trans-identified natal female therapist said that “receiving gender-affirming care can often significantly stabilize client’s [sic] mental health.” The California therapist who claimed surgical castration made a huge difference in the life of a homeless person told the forum that withholding hormones can intensify mental health symptoms and suggested hormone therapy is “harm reduction and so doing nothing is not a ‘neutral option.’”

WPATH’s SOC8 also states that “studies suggest mental health symptoms experienced by [transgender/ gender diverse] people tend to improve” following sex-trait modification interventions despite there being no good quality research to support this claim.<sup>206</sup>

Suggesting that hormonal and surgical sex-trait modification interventions can improve depression, PTSD, and even schizophrenia is a breach of the requirement to present accurate information to the patient when obtaining informed consent. It is akin to a cosmetic surgeon telling a patient that a nose job is the remedy for depression or breast augmentation is the cure for bipolar disorder.

Due to such false promises, people suffering from gender dysphoria often have unrealistic expectations about undergoing sex-trait modification procedures. The anticipation and excitement about starting cross-sex hormones or having a mastectomy or genital surgery often become a focal point for the distressed mind, with individuals pinning their hopes on these medical procedures to resolve all their pain and suffering. WPATH members endorsing sex-trait modification drugs and surgeries as a cure for mental distress do little to dispel

these fantasies.

However, it does not have to be this way. Approximately two decades ago, at the Portman adult gender clinic in London, a British psychiatrist demonstrated that giving trans-identified patients a realistic idea of what sex-trait modification can achieve is a highly effective strategy for quelling the desire for medical intervention and minimizing transition regret.

Dr. Az Hakeem ran therapy groups that combined patients wishing to embark upon surgical transition with post-operative transsexuals who regretted their surgeries. In an interview, he described the pre-operative group as one of excitement and euphoria and the post-operative group as one of “mourning, depression, and sadness.”

“The typical pattern was gender dysphoria, transgender euphoria, and then transgender dysphoria,” Hakeem said of the post-op regretters. “They realized they didn’t really feel that authentic in their transgender identity, so they were still feeling just as inauthentic, but just in a different body.” Hakeem observed that this process took, on average, seven years, which casts further doubt on the validity of short-term follow-up studies showing high patient satisfaction post-transition rates.<sup>207</sup>

Meyer and Hoopes of Johns Hopkins made the same observation in 1974. They described an “initial phase of elation” that extended for two to five years post-transition, but after that honeymoon period is over, “the patient is overtaken by the painful realization that nothing has really changed except certain elements of body configuration.”<sup>208</sup> This honeymoon period has also been observed more recently.<sup>209</sup>

The aforementioned first Dutch follow-up study in 1988 described those in the early stages of the sex trait

205 Ibid (n.177-179)

206 Ibid (n.94)

207 Hughes, M. (2023). Dr. Az Hakeem: Trans Is the New Goth. Public. <https://public.substack.com/p/dr-az-hakeem-trans-is-the-new-goth#details>

208 Meyer, J. K., Hoopes, J. E., & Meyer, J. K. “The Gender Dysphoria Syndromes: A Position Statement on So-Called “Transsexualism.”” *Plastic and Reconstructive Surgery* 54, no. 4 (1974). [https://journals.lww.com/plasreconsurg/fulltext/1974/10000/the\\_gender\\_dysphoria\\_syndromes\\_\\_a\\_position.9.aspx](https://journals.lww.com/plasreconsurg/fulltext/1974/10000/the_gender_dysphoria_syndromes__a_position.9.aspx).

209 Nobili, A., Glazebrook, C., & Arcelus, J. “Quality of Life of Treatment-Seeking Transgender Adults: A Systematic Review and Meta-Analysis.” *Reviews in Endocrine and Metabolic Disorders* 19, no. 3 (2018): 199-220. <https://doi.org/10.1007/s11154-018-9459-y>.

modification journey as “taking a loan on the future,” and the study concluded that “[sex reassignment surgery] is no panacea.” The researchers observed that the “[a]llleviation of gender problems does not automatically lead to a happy and lighthearted life” and that, on the contrary, “SRS can lead to new problems.”<sup>210</sup>

It is essential that people wishing to embark upon life-altering sex-trait modification procedures be brought face-to-face with this reality. There is no evidence in the files that WPATH members realistically prepare patients for the difficulties of life after hormonal and surgical body modification. By contrast, Hakeem’s innovative approach proved very effective, with almost all of his preoperative patients ultimately not undergoing surgery because they understood the limitations of their “fantasy solution,” and the small number who went through with it had much more realistic expectations.

### Consumer-Driven Gender Embodiment

There has been a significant increase in the number of young people identifying as “non-binary” in recent years, and WPATH now advocates for these individuals to be eligible for hormonal and surgical sex-trait modification interventions.<sup>211</sup>

The nonbinary chapter of WPATH’s SOC8 states that healthcare providers must avoid overly focusing on gender-related distress because “it is also important to consider experiences of increased comfort, joy, and self-fulfillment that can result from self-affirmation and access to care.”<sup>212</sup>

Gender nullification surgeries, defined by WPATH as “procedures resulting in an absence of external primary sexual characteristics,” and bigenital surgeries, such as the creation of a pseudo-vagina cavity without amputating the penis, are the end result of activists overtaking WPATH.

In WPATH’s SOC8, there is a shopping list of extreme body modification procedures which includes options such as vaginoplasty “with retention of penis and/or testicle” and “flat front” procedures.<sup>213</sup> These surgeries do not even meet the definition of experimental, as they are not being studied in any controlled manner.

Members inside the WPATH messaging forum discuss best practices for these “non-standard” procedures.

When Dr. Thomas Satterwhite, a renowned California surgeon, asks for the group’s input for “non-standard” procedures such as “top surgery without nipples, nullification, and phallus-preserving vaginoplasty,” no one raised any ethical questions about the destruction of perfectly healthy reproductive organs to fulfill customized body modification desires. Instead, members of the group policed Satterwhite’s language, with one therapist arguing that such procedures could also be “selected by those with binary gender identities;” another therapist who identifies as non-binary agreed and called his language “cisgenderist,” and a trans-identified natal female medical school student stressed the importance of “de-gendering” sex-trait modification procedures. In the SOC8, these procedures are euphemistically referred to as “individually customized” surgeries.

Further demonstrating WPATH’s priorities when it comes to radical and untested surgeries, Dr. Rajveer S. Purohit outlined the important topics to discuss with patients before their nullification surgery, such as whether they want orgasms or not and if they want to sit while urinating. Completely absent from the discussion was any mention of the impact such drastic procedures will have on a patient’s fertility, sexual function, ability to form long-term stable romantic partnerships or general state of health.

210 Ibid (n.125)

211 Chew, D., Tollit, M. A., Poulakis, Z., Zwickl, S., Cheung, A. S., & Pang, K. C. “Youths with a Non-Binary Gender Identity: A Review of Their Sociodemographic and Clinical Profile.” *The Lancet Child & Adolescent Health* 4, no. 4 (2020): 322-30. [https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642\(19\)30403-1/fulltext](https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(19)30403-1/fulltext).

212 Ibid (n.94)

213 Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L. C., Deutsch, M. B., Ettner, E., et al. “Standards of Care for the Health of Transgender and Gender Diverse People, Version 8.” [In eng]. *Int J Transgend Health* 23, no. Suppl 1 (2022): Ch. 13. <https://doi.org/10.1080/26895269.2022.2100644>.



In one post, Satterwhite gives a disturbing account of a patient who became “dangerous and threatening” while still undergoing post-op care as a result of “undiagnosed mood disorders that did not surface until post-op.” This is proof that not every patient benefits from extreme body modification procedures being available on demand with no prior psychological assessment or psychotherapeutic support.

### Valuing Patient Autonomy Over Risk Aversion

WPATH places a high value on patient autonomy and a low value on minimizing potential harm. Or rather, it conceptualizes harm, as in “do no harm,” as unfulfilled consumer desire.

In 2022, the aforementioned activist professor who believes developmentally delayed minors ought to be allowed to consent to life-altering experimental hormones and surgeries, posted in the forum in defence of “trans people whose embodiment goals do not fit dominant expectations,” such as those who want “mastectomies without nipples, mastectomies for people who do not want breasts from estrogen [and] vagina-preserving phalloplasties.”

The professor, who has previously described “trans embodiment as a free-form artistic expression of gender,” and believes teenagers should have the right to treat their body like a “gendered art piece,”<sup>214</sup> demonstrates the flawed beliefs held within WPATH when claiming that transgender health care is about creating bodies that “challenge cisnormativity.”

“Trans health is about bodily autonomy, not normalizing bodies,” said the activist professor in the files. “We didn’t reject the idea that you can’t change your gender only to double down on the idea that gender is binary and defined by genitals.”

In a separate discussion about “non-standard” surgeries, a Minnesota therapist who believes WPATH

needs a “different way of looking at gender that is not through a cisgenderist gaze” asked the group, “If adult patients have body autonomy, what is the issue with having top surgery without nipples, for example?” adding that “[s]urgical tattoos can help if the patient changes their mind later.”

These comments are a clear indication that WPATH is not scientific. Medical professionals devoted to providing ethical care to their patients should not destroy healthy reproductive organs in pursuit of creating smooth, sexless bodies or second sets of genitals. Such highly invasive, life-altering procedures are not an attempted remedy for a recognised psychiatric condition but are instead consumer-driven extreme body modification masquerading as medicine. This is a violation of medical ethics and the Hippocratic Oath.

### A Brave New World

Many WPATH members see themselves as being on the vanguard of a new medical frontier. A British psychiatrist took exception to Satterwhite’s use of the term “non-standard,” suggesting that such interventions “may become standard in the future.”

A California physician who once famously quipped that if teenage girls later in life regret having their healthy breasts amputated, they can just “go and get them,”<sup>215</sup> replied to say that the field of gender care will soon be “overhauled by younger people,” something she is thankful for. She called for medical and surgical interventions to be reframed as an individual’s “embodiment of gender” rather than being “responsive to the poorly defined ‘gender dysphoria.’”

In the Identity Evolution Workshop, Berg even discussed embodiment goals for children as a guide for medical decision-making. “Embodiment is certainly a concept that I’m using a lot more of with my adolescents and children,” said the prominent WPATH expert.

214 Ashley, F. “Gatekeeping Hormone Replacement Therapy for Transgender Patients Is Dehumanising.” [In eng]. *J Med Ethics* 45, no. 7 (Jul 2019): 480-82. <https://doi.org/10.1136/medethics-2018-105293>.

215 “[Physician] Explains Why Mastectomies for Healthy Teen Girls Is No Big Deal.” Youtube, 2019, <https://www.youtube.com/watch?v=5Y6espcXPJk>.



Despite the unusual nature of the non-binary procedures, the files contain evidence that insurance companies provide coverage for these experimental body modification surgeries, as shown when Satterwhite tells the group that his clinic in San Francisco is consistently able to get insurance coverage for his patients. Dr. Daniel Dugi of Oregon Health and Science University confirms also having no trouble getting insurance coverage.

There have been two cases in Ontario, Canada of non-binary individuals winning the right to have the surgical creation of a second set of fake-genitals paid for by the province's taxpayers, decisions that will pave the way for such procedures to be covered by provincial health insurance.<sup>216,217</sup> In *Ks v Ontario*, the non-binary chapter of WPATH's SOC8 is quoted extensively throughout, and the Ontario Health Services Appeal and Review Board adopted the logic and vocabulary of WPATH in its ruling, stating that gender diverse presentations may lead to "individually customized surgical requests" that ought to be covered by provincial health plans.<sup>218</sup>

While realizing extreme body modification goals may be very gratifying for a person, at least in the short term, governments and insurance companies should not confuse this with medicine and necessary medical care. Non-binary surgeries demonstrate WPATH's total abandonment of science and medicine in pursuit of unrestrained consumerism.

A counselor from Virginia predicted a "wave of non-binary affirming requests for surgery" and informed the group he had worked with "clients who identify as non-binary, agender, and Eunuchs" who had requested "atypical surgical procedures, many of which either don't

exist in nature or represent the first of their kind."

Perhaps the best indication that WPATH has lost its way as a medical organization is the group's decision to include an entire chapter in its SOC8 dedicated to gender-affirming care for people who identify as eunuchs. In the glossary, the world-leading transgender health group defines eunuch-identified men as individuals "assigned male at birth" who feel that "their true self is best expressed by the term eunuch. Eunuch-identified individuals generally desire to have their reproductive organs surgically removed or rendered non-functional."

The Eunuch chapter contains not only the claim that children can be eunuch-identified, but also a hyperlink to the Eunuch Archives website where anonymous men with castration fetishes congregate and share their child castration fantasies.<sup>219</sup> In April 2023, on TikTok, a popular WPATH-affiliated gender surgeon advertised gender-affirming care for people who identify as eunuch to her 250K+ young followers.<sup>220</sup>

During WPATH's 2022 International Symposium in Montreal, the coauthor of the SOC8 eunuch chapter spoke about the first "eunuch-identified" patient he ever saw, who was a 19-year-old man living in his parent's basement, who "may have been on the autism Asperger's spectrum," and wanted to revert to a prepubertal state.<sup>221</sup> The young man didn't explicitly identify as a eunuch. The WPATH expert had applied the label to him. "I deduced it just because it was on my radar," he explained to the audience. In other words, instead of viewing this patient as a troubled individual in need of deep psychotherapeutic support, the WPATH expert labeled him a eunuch-identified person in need of gender-affirming surgical castration. Reframing

216 "Ks V Ontario (Health Insurance Plan)." CanLII, 2023, <https://www.canlii.org/en/on/onhsarb/doc/2023/2023canlii82181/2023canlii82181.html?searchUrlHash=AAAAAQANdmFnaW5vcGxhc3R5IAAAAAAB&resultIndex=1>.

217 "Ohip Reverses Course, Will Fund Gender-Affirming Surgery for Ottawa Public Servant." The Globe and Mail, 2023, <https://www.theglobeandmail.com/canada/article-ohip-gender-affirming-surgery-case/#:~:text=OHIP%20has%20reversed%20its%20stance,procedure%20for%20nearly%20a%20year.>

218 Ibid (n.216)

219 Gluck, G. (2022). Top Trans Medical Association Collaborated With Castration, Child Abuse Fetishists. ReduXX. <https://reduxx.info/top-trans-medical-association-collaborated-with-castration-child-abuse-fetishists/>

220 Gender Surgeon (2023). #testicleremoval #orchietomy #eunuch. <https://www.tiktok.com/@gendersurgeon/video/7218932161934822702>

221 "Of Eunuchs and Wannabes." Year Zero, 2022, <https://wesleyyang.substack.com/p/of-eunuchs-and-wannabes>.

such serious psychiatric disorders as “identities” to be affirmed and resolved with chemical and surgical castration is an enormous breach of medical ethics and a clear indication that WPATH does not have the health and well-being of patients as its priority.

At the end of the Eunuch session, which was held in the grand salon of the conference venue, not off in a side room, Satterwhite and Dr. Thomas W. Johnson, the lead author of the SOC8 Eunuch chapter, and its co-author, Dr. Michael Irwig, had an interesting conversation. Satterwhite took to the microphone and told of how Johnson had helped him overcome his emotional discomfort in one of his earliest cases of a gay man who wanted to be castrated. He asked Johnson for advice on how to “get more surgeons on board” with performing this

type of procedure, explaining that he’d had a mixed response from fellow attendees at the conference to his willingness to perform “non-standard” genital surgery.

After commending Satterwhite for “being open to new ideas,” Johnson said he hoped “having the [eunuch] chapter in the Standards of Care will open the possibilities,” that surgeons will see it and “say, yep, this is something that I ought to be willing to consider.” Irwig agreed, saying it was “huge” that eunuch was now in the SOC, because now doctors wouldn’t have to fear losing their license for castrating these psychologically troubled men.

“The more sessions like this we have, the more educated people will get, and then we’ll get more people like you to be able to do this,” said Irwig to Satterwhite.

## PAST CASES OF PSEUDOSCIENTIFIC HORMONAL AND SURGICAL EXPERIMENTS ON CHILDREN AND VULNERABLE ADULTS

History is full of examples of the medical world getting things catastrophically wrong and yet taking decades to face up to the mistake and self-correct. Today's scandal perpetrated by WPATH combines elements of past attempts to cure mental illness by surgical means such as lobotomy and ovariectomy with the misguided experiment by pediatric endocrinologists to correct the height of tall girls and short boys using puberty blockers and hormones. There is also the scandal in the recent past of a surgeon amputating the healthy legs of men with body integrity identity disorder that bears a striking resemblance to the type of medical care WPATH endorses.

Examining historical medical blunders offers insights into the current scandal unfolding in gender clinics. By distancing ourselves from our cultural biases and preconceptions, a clearer view of the ease with which doctors are led astray emerges.

### Lobotomy

**A case study comparing the pseudoscientific surgical destruction of healthy brains in the 20th century and the pseudoscientific surgical destruction of healthy genitals of vulnerable people today**

In the mid-20th century, a widely held belief in the medical world was that the most effective and humane treatment for mental illness was the lobotomy: a brutal surgical procedure that involved blindly swinging sharp instruments in the brain to sever the frontal lobe connections.

Despite the obvious dangers and devastating side effects, the medical community rapidly embraced the

practice of performing lobotomies as a treatment for a wide range of mental disorders, including depression, obsessive-compulsive disorder (OCD), epilepsy, and schizophrenia.

Lobotomists were not vilified; rather, they were held in high regard by many. Antonio Egas Moniz, the inventor of the lobotomy, was honored with the Nobel Prize in 1949 for his contribution to medicine. Walter Freeman and James Watts, who popularized the procedure in the United States, were warmly received at annual American Medical Association (AMA) meetings, where they set up “psychosurgery” exhibits providing information about their brain-mutilating surgery.

While there was early opposition to the brutality and imprecision of the procedure, little of it was published in medical journals because, at the time, to criticize fellow doctors was viewed as unethical. Instead, the prestigious *New England Journal of Medicine* gave the procedure scientific validity by publishing an article touting the operation as being based “on sound physiological observation.”<sup>222</sup>

The popular press also played a crucial role. In 1936, the *New York Times* called the procedure “a turning point in treating mental cases,” predicting that Freeman and Watts were likely “going down in medical history as another shining example of therapeutic courage,” and in 1937, claimed the surgery “cuts away sick parts of the human personality and transforms wild animals into gentle creatures.”<sup>223,224</sup> Over the next five years, lobotomy was frequently featured in popular publications, including *Reader's Digest*, *Time*, and *Newsweek*. The narrative

222 “The Surgical Treatment of Certain Psychoses.” *New England Journal of Medicine* 215, no. 23 (1936): 1088-88. <https://sci-hub.ru/10.1056/NEJM193612032152311>.

223 “Find New Surgery Aids Mental Cases; Drs. Freeman and Watts Say Operation on Brain Has Eased Abnormal Worry. 6 Selected Patients Gain No Data yet Available on Permanent Effects, Scientists Tell Southern Medical Group.” *The New York Times*, 1936, <https://www.nytimes.com/1936/11/21/archives/find-new-surgery-aids-mental-cases-drs-freeman-and-watts-say.html>.

224 “Surgery Used on the Soul-Sick Relief of Obsessions Is Reported; New Brain Technique Is Said to Have Aided 65% of the Mentally Ill Persons on Whom It Was Tried as Last Resort, but Some Leading Neurologists Are Highly Skeptical of It.” *The New York Times*, 1937, <https://www.nytimes.com/1937/06/07/archives/surgery-used-on-the-soulsick-relief-of-obsessions-is-reported-new.html>.

overall was positive, downplaying the barbaric reality of the procedure.<sup>225</sup>

Many desperate patients and their families sought lobotomies after reading these articles. Conditions in mental asylums at the time were deplorable, and alternative remedies for mental illness, such as insulin coma therapy and electroshock therapy, were also harsh and often violent. Therefore, even though a lobotomy often left patients in a state of “surgically induced childhood,” to many, this was preferable to the other options available.

At no point during lobotomy’s rapid rise in popularity did any of the significant American medical associations, including the American Psychiatric Association and the American Medical Association, stand in official opposition to the surgery.

Freeman, who invented the “transorbital lobotomy,” which involved hammering a surgical instrument resembling an ice pick through a patient’s eye socket and into the brain, considered his procedure a success if his patients were able to leave the asylum and be cared for at home “at the level of a domestic invalid or household pet.”<sup>226</sup> He also became convinced that the earlier the procedure was performed, the better because of the misguided belief that patients were destined to deteriorate otherwise. This meant he advocated for the surgery as a first line of treatment for those with only mild mental illness.

Many of Freeman’s patients didn’t even meet his questionable measure of success, with some ending up permanently disabled and approximately 15% dying.<sup>227</sup> In 1941, Rosemary Kennedy, sister of President John F. Kennedy, became Freeman’s most famous victim when her lobotomy left her condemned to live out the rest of her days in a private psychiatric hospital, unable to care for herself,

barely able to speak, and with no memory of her family.<sup>228</sup>

But what is arguably Freeman’s most egregious crime was that he performed lobotomies on children, 19 in total, with 11 such cases described in the 1950 edition of his book, *Psychosurgery*.<sup>229,230</sup> The youngest was just four years old, and two out of the 11 died of cerebral hemorrhages.

Even as Moniz was awarded the Nobel Prize in 1949 for the invention of lobotomy, and in its reporting, the New York Times declared that “surgeons now think no more of operations on the brain than they do of removing an appendix,” opposition to the procedure was starting to mount.<sup>231</sup> Critics highlighted the severe side effects experienced by many patients, raised concerns about the criteria used to measure success, and accused surgeons of conducting procedures without preliminary psychiatric evaluations.

However, it was the invention of the antipsychotic drug Chlorpromazine that triggered lobotomy’s precipitous fall in popularity because, all along, it was the lack of humane alternative treatments that had caused psychiatrists to go to such desperate lengths.

In 1967, after what was destined to be his last patient died of a brain hemorrhage, a disgraced Freeman was stripped of his hospital privileges. He spent the rest of his days driving across the US, tracking down his patients and their families, searching for proof that his beloved procedure had helped and not harmed.

The horrifying story of lobotomy should have served as a cautionary tale for the medical world, illustrating the dire consequences that can occur when doctors swiftly embrace novel, innovative procedures without first subjecting them to thorough scientific scrutiny to establish their value, safety, and effectiveness.

225 Diefenbach, G., Diefenbach, D., Baumeister, A., & West, M. “Portrayal of Lobotomy in the Popular Press: 1935-1960.” *Journal of the history of the neurosciences* 8 (05/01 1999): 60-9. <https://doi.org/10.1076/jhin.8.1.60.1766>.

226 Whitaker, R. *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*. Basic Books, 2001. <https://archive.org/details/madinamericabads00whit>

227 “Lobotomy: The Brain Op Described as ‘Easier Than Curing a Toothache.’” BBC News, 2021, <https://www.bbc.com/news/stories-55854145>.

228 “Postmodern Lobotomy Blues.” *Compact Magazine*, 2023, <https://compactmag.com/article/postmodern-lobotomy-blues>.

229 “The Lobotomist.” PBS, 2008, 48:20. <https://www.pbs.org/wgbh/americanexperience/films/lobotomist/>.

230 Offit, P. A. *Pandora’s Lab: Seven Stories of Science Gone Wrong*. National Geographic Books, 2017.

231 “Explorers of the Brain.” *The New York Times*, 1949, <https://www.nytimes.com/1949/10/30/archives/explorers-of-the-brain.html>.

But 70 years later, we find ourselves without the moral high ground. In the age of evidence-based medicine, we once again find ourselves witness to a medical world performing surgical mutilation on healthy bodies in the quest to cure mental illness. But instead of targeting the brain, today's surgeons target the genitals.

In both medical scandals, the victims are either minors or the mentally ill (or both), and the surgeries performed result in permanent disfigurement and disability. The most fortunate of Freeman's patients managed to live semi-independent lives, holding down low-skilled jobs, but most weren't so lucky. Many had their long-term memory destroyed and struggled even with the most basic tasks. Many were left permanently disabled.

In today's scandal, in the best-case scenario, male patients are left with a cavity that needs to be dilated for life and drastically reduced sexual function. The less fortunate endure severe complications, such as neovaginal stenosis, urinary issues, and fistulas. Ritchie Herron, a detransitioned man who underwent vaginoplasty during a mental health crisis, describes his life post-surgery as a living nightmare. "There is no dignity in living like this," said the 32-year-old victim of today's medical crime, who suffers from ongoing pain, numbness, and urinary dysfunction.<sup>232,233</sup>

Female patients undergo a procedure called phalloplasty that involves surgeons harvesting tissue from a donor site, usually the forearm but sometimes the thigh, and using the tissue to fashion a non-functional pseudo-penis. The surgery comes with an extraordinarily high complication rate and typically requires a full hysterectomy and vaginectomy, which is the surgical removal of the

vagina.<sup>234,235</sup> A 2021 study of 129 females who underwent the risky procedure to construct a pseudo-penis found the group reported 281 complications requiring 142 revisions.<sup>236</sup>

Both lobotomies and genital surgeries also involve the destruction of a core part of a person's humanity. Freeman and Watts noted that each of their patients lost "something by this operation, some spontaneity, some sparkle, some flavor of the personality." Today's gender surgeons are attacking an equally important aspect of what makes us human. Our sexual identities are an intrinsic part of who we are, making the amputation of genitals akin to performing a sexual lobotomy.

Gender surgeons, like the lobotomists who came before them, bypass ethical requirements that a surgical intervention be proven safe and beneficial before it is rolled out into mainstream medical practice. No long-term studies existed to prove that the benefits of lobotomy outweighed the harms, and the same can be said for today's genital surgeries. The few long-term studies that exist show significantly impaired social functioning, high rates of mental illness, and elevated suicide risk. Yet despite the lack of good quality science to support such drastic life-altering surgeries, just as the AMA and the APA did not openly condemn the medical crime of lobotomy, today those same organizations endorse minors and mentally ill adults undergoing genital amputation at the hands of WPATH surgeons. The reason is that they regard sex trait modification as a "human rights" issue first and foremost, and only secondarily, if at all, as a medical question.

In 1941, the New York Times described lobotomy patients as having "worries, persecution complexes, suicidal intentions, obsessions, indecisiveness and nervous

- 232 "Heartbroken' Father Sues NHS to Stop Autistic Son's Sex Change." The Telegraph, 2023, <https://www.telegraph.co.uk/news/2023/06/04/nhs-gender-clinic-judicial-review-autistic-son-sex-change/>.
- 233 Ritchie, "This Isn't Even the Half of It. And This Isn't Regret Either, This Is Grief and Anger..." @TullipR, June 13, 2022, 2:57 PM, <https://twitter.com/TullipR/status/1536422563458465793?s=20>.
- 234 Rashid, M., & Tamimy, M. S. "Phalloplasty: The Dream and the Reality." [In eng]. *Indian J Plast Surg* 46, no. 2 (May 2013): 283-93. <https://doi.org/10.4103/0970-0358.118606>.
- 235 Wierckx, K., Van Caenegem, E., Elaut, E., Dedeker, D., Van de Peer, F., Toye, K., Weyers, S., et al. "Quality of Life and Sexual Health after Sex Reassignment Surgery in Transsexual Men." [In eng]. *J Sex Med* 8, no. 12 (Dec 2011): 3379-88. <https://doi.org/10.1111/j.1743-6109.2011.02348.x>.
- 236 Robinson, I. S., Blasdel, G., Cohen, O., Zhao, L. C., & Bluebond-Langner, R. "Surgical Outcomes Following Gender Affirming Penile Reconstruction: Patient-Reported Outcomes from a Multi-Center, International Survey of 129 Transmasculine Patients." [In eng]. *J Sex Med* 18, no. 4 (Apr 2021): 800-11. <https://doi.org/10.1016/j.jsxm.2021.01.183>.

tensions literally cut out of their minds with a knife by a new operation on the brain,” giving the brutal surgery the air of a miracle cure.<sup>237</sup> Almost a century later, in the WPATH forum, the California therapist told her colleagues of the remarkable healing power of surgical castration for her mentally ill patients, who were put “on the road to emotional recovery” and presumably lived happily ever after.

Today, many patients report being satisfied with the outcome of their genital surgery despite being plagued by complications and experiencing significant social and romantic difficulties. Likewise, many families were genuinely grateful to Freeman for helping their loved ones despite the enormous burden of care placed upon them by the surgery and the devastating impact on the patient. Both situations suggest a certain level of self-deception, or what the early Dutch researchers worried was happiness “distorted by wishful thinking.” Families who consented to their loved one undergoing a lobotomy would have an incentive to cling to the belief that it was the right decision, wilfully ignoring the obvious signs that it wasn’t. Many adolescents, or their parents, as well as vulnerable adults may face a similar internal struggle today.

To understand how the medical world could have so swiftly endorsed lobotomies and why families and even the victims may have been grateful for the procedure, it is necessary to paint a picture of life for the severely mentally ill at the turn of the 20th century. This was an era long before the invention of antipsychotic drugs when the outlook for the mentally ill was bleak. Most ended up in overcrowded, understaffed mental asylums where the conditions were deplorable. Those suffering from the worst cases were kept restrained and in isolation, sometimes for years on end. One investigation of mental asylums in the

United States found patients crammed naked in a dark room, the floor filthy with human waste.<sup>238</sup>

The field of psychiatry’s desperation in the early decades of the 20th century gave rise to several brutal somatic remedies, from insulin coma therapy<sup>239</sup> to malaria therapy,<sup>240</sup> as well as the more widely-known electroshock treatments. These were risky and violent, and success was uncertain. It was in this context that news of Moniz’s groundbreaking psychosurgery emerged. Psychiatrists, asylum staff, families, and the patients themselves were desperate for a solution. When lobotomy enabled patients to leave the asylum and be cared for at home by loved ones, or at least allowed the most violent cases to escape the confines of isolation and move freely within the ward, many saw it as a humane option. This resulted in a powerful, willful blindness to the barbaric nature of the procedure and its associated side effects.

But the world of today’s victims could not be more different. The minors and vulnerable adults seeking surgical solutions to their poorly defined psychiatric condition are not confined to mental asylums, restrained in straitjackets, or chained to walls in isolation wards. They are not subjected to electroconvulsive shock therapy and face a lifetime of confinement and misery. Most are simply caught up in a mad cultural moment, suffering from a culture-bound mental illness that has produced an identity that is almost certainly transient.

For these young patients who still have their whole lives ahead of them, there is an ethical, non-invasive approach to treatment available with a strong track record of success: watchful waiting, coupled with psychotherapy as needed. All available evidence from the time before WPATH politicized gender medicine indicates that the majority of minors suffering from distress about their sex

237 “Turning the Mind inside Out.” Saturday Evening Post, 1941, <https://picryl.com/media/turning-the-mind-inside-out-saturday-evening-post-24-may-1941-page-18-2d7a77>.

238 Maisel, A. Q. “Bedlam 1946: Most Us Mental Hospitals Are a Shame and a Disgrace.” Life Magazine 20, no. 18 (1946): 102-18. <https://mn.gov/mnddc/parallels2/prologue/6a-bedlam/bedlam-life1946.pdf>.

239 Jones, K. “Insulin Coma Therapy in Schizophrenia.” Journal of the Royal Society of Medicine 93, no. 3 (2000): 147-49. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1297956/pdf/10741319.pdf>.

240 “The Psychiatrist Who Gave His Patients Malaria.” Psychology Today, 2023, <https://www.psychologytoday.com/ca/blog/psychiatry-a-history/202303/the-psychiatrist-who-gave-his-patients-malaria>.



will reconcile with their bodies during or after puberty—assuming they are not socially transitioned and medicalized. Watchful waiting, caring support, and allowing the young person to grow and mature is the humane alternative to WPATH’s “gender lobotomy.”<sup>241</sup>

The scientific literature on adults is less conclusive, but for the severely mentally ill patients seeking genital surgery, deep psychotherapeutic work to alleviate their complex mental health issues and uncover the origin of their gender distress is preferable to ignoring all comorbidities and leaping directly to genital mutilation. Often, as Dr. Az Hakeem at the Portman clinic demonstrated, bringing the patients face-to-face with the reality of genital surgery is enough to quell the patient’s obsessive desire.

But because WPATH is not a medical group seeking to find the best way to care for people suffering from gender dysphoria, its members consider attempting to avert the need for invasive, life-altering surgical intervention to be “conversion therapy.” So instead, WPATH members advocate for surgical interventions as the only line of treatment, even for minors and the severely mentally ill, much the same as Freeman and his colleagues believed lobotomy was the only hope for the poor unfortunate souls confined to mental asylums.

Freeman saw himself as the savior of the severely mentally ill, believing that he gave hope to the hopeless. At the height of his career, he could never have imagined a day when his miraculous cure would be reviled and considered an atrocity. The same can be said for WPATH and its members. Spurred on by the thought of themselves as civil rights heroes fighting on behalf of the oppressed, they see themselves as being on the cutting edge of medicine, providing necessary medical care to patients in need. However, we believe that adolescents and vulnerable adults undergoing the surgical destruction of healthy genitals is destined to be recorded in history as a crime of

equal or even greater magnitude than the lobotomy.

### Ovariectomy

**A case study comparing the attempt to cure mental illness with gynecological surgery in the 19th century with today’s attempt to cure mental illness with gynecological surgeries and bilateral mastectomies**

One of the greatest medical scandals of the 19th century was the practice of removing healthy ovaries as the treatment for a variety of mental illnesses in women, ranging from “menstrual madness,” nymphomania, masturbation, and “all cases of insanity.” This practice, known as ovariectomy, enjoyed the support of many of the leading gynecologists and psychiatrists of the era, and it is estimated that over 100,000 women had their healthy ovaries removed between 1872 and 1900.<sup>242</sup> This being a time long before the invention of antibiotics and adequate surgical cleanliness procedures, approximately 30% of the women died as a result of this medically unnecessary operation.<sup>243</sup>

The practice had its origins in reflex theory, the pseudoscientific idea that the spine connected all organs in the body, meaning one organ could produce symptoms in a distant organ, including the brain. This logic caused patients to become fixated on organs that had nothing to do with their symptoms and resulted, during the period we will describe, in droves of women seeking the removal of their ovaries as a means to resolve their mental distress.

This, combined with the era’s fashionable belief that a variety of complaints, including hysteria, neurasthenia (what would today be called chronic fatigue syndrome), menstrual madness (premenstrual dysphoric disorder, or PMDD), and lunacy, were the result of masturbation and nymphomania, set the scene for the ovaries to be implicated in women’s mental disorders. And from implicating the ovaries in the cause of mental disorders, it was a natural progression that surgeons should want to

241 Ibid (n.2-4)

242 Studd, J. “Ovariectomy for Menstrual Madness and Premenstrual Syndrome—19th Century History and Lessons for Current Practice.” [In eng]. *Gynecol Endocrinol* 22, no. 8 (Aug 2006): 411-5. <https://doi.org/10.1080/09513590600881503>.

243 Longo, L. D. “The Rise and Fall of Battley’s Operation: A Fashion in Surgery.” *Bulletin of the History of Medicine* 53, no. 2 (1979): 256.



remove them as a treatment.

In 1872, within the space of just weeks, two ovariectomies were performed on opposite sides of the Atlantic. German Alfred Hegar performed the world's first on a healthy woman as a treatment for psychological distress, but his patient died a week later of peritonitis. Not a month later, English gynecologist Lawson Tait and American Robert Battey, unaware of Hegar's attempt, removed the ovaries of a woman who suffered from menstrual symptoms and convulsions that left her in a semi-comatose state. She almost met the same fate as Hegar's patient after developing sepsis but later recovered and was pronounced cured of her female woes.

The procedure was destined to take Battey's name and became known as Battey's Operation. Battey believed that madness in women was "not infrequently caused by uterine and ovarian disease." Battey is believed to have performed the procedure on several hundred women between 1872 and 1888, and it enjoyed a period of immense popularity in most of Europe and across the US, with women having their ovaries excised for a range of disorders from epilepsy to hysterical vomiting. It was considered a therapy to prevent "moral decline."

According to medical historian Edward Shorter, justification for performing this life-threatening surgery on women was found in data that was gathered, without statistical controls, showing that a disproportionate number of mentally ill women suffered from pelvic lesions. For instance, one study carried out by Russian gynecologist Valentin Magnan found that 35 out of his 45 patients with mental illness or hysteria had various genital lesions, and only 4 had no gynecological abnormality.<sup>244</sup> Of course,

these findings were meaningless in the absence of a control group, but this was an era long before the development of evidence-based medicine.

Thus, the medical world rapidly adopted the dangerous, potentially deadly treatment, and it wasn't long before psychiatrists were recommending the surgery for "all cases of lunacy." It became so popular that psychiatric hospitals opened operating rooms where surgeons could remove the ovaries of female inmates.<sup>245</sup>

Supporters of ovariectomy considered it "one of the unequalled triumphs of surgery," and considered anyone who sought to deny women this medically necessary treatment to be "wanting in humanity" and "guilty of criminal neglect of patients."<sup>246</sup> This was the view held by the leading surgeons of the time, including Lawson Tait, one of the pioneers of the procedure. By its opponents, the operation was called "pernicious and dreadful,"<sup>247</sup> and the surgeons performing it "gynecological perverts."<sup>248</sup>

A sham surgery performed by James Israel in Paris in 1880 wasn't enough to dampen the enthusiasm. Israel claimed to have cured a woman by making an incision and sewing it back up, thereby proving the placebo effect and psychosomatic nature of the symptoms.<sup>249</sup> But Hegar is said to have performed an ovariectomy on her later that year to cure her of her incessant vomiting. Hegar then encouraged German surgeons to embrace the procedure, which, according to gynecologist and medical historian John Studd, is an indication that it was seen as being on the cutting edge of medicine.<sup>250</sup>

Women who had imbibed the popular reflex theory of the day, and begun to fixate on their reproductive organs as the source of their mental distress, began presenting to

244 Shorter, E. *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era*. Simon and Schuster, 2008: 210. <https://www.simonandschuster.ca/books/From-Paralysis-to-Fatigue/Edward-Shorter/9780029286678>.

245 "Removal of the Ovaries, Etc., in Public Institutions for the Insane." *Journal of the American Medical Association* XX, no. 9 (1893): 258-58. <https://doi.org/10.1001/jama.1893.02420360034006>.

246 *Ibid* (n.243)

247 *Ibid* (n.243)

248 Barnesby, N. *Medical Chaos and Crime*. M. Kennerley, 1910. <https://catalog.libraries.psu.edu/catalog/39665261>.

249 Studd, J. "Ovariectomy for Menstrual Madness and Premenstrual Syndrome--19th Century History and Lessons for Current Practice." [In eng]. *Gynecol Endocrinol* 22, no. 8 (Aug 2006): 411-5. <https://doi.org/10.1080/09513590600881503>.

250 *Ibid* (n.249)

gynecologists requesting to be “Battley-ized” as the procedure gained in popularity.<sup>251</sup>

Dr. William Goodell called for the surgery to be performed for “all cases of insanity,” an opinion supported by others, assuring his fellow gynecologists: “If the operation be not followed by a cure, the surgeon can console himself with the thought that he has brought about a sterility in a woman who might otherwise have given birth to an insane progeny.”<sup>252</sup> Goodell believed that such a woman was destined to “transmit the taint of insanity to her children and her children’s children for many generations.”<sup>253</sup>

Some medical reports included the self-reported satisfaction of women who had undergone the surgery. One woman told of how she was so desperate before the operation that she almost took her own life but stated that she was “a well, happy, and cheerful girl” after having her healthy ovaries removed.<sup>254</sup>

Geroge H. Rohé, an ovariectomy enthusiast, operated for a wide range of mental disorders, including cases of epilepsy, melancholia, and hysterical mania. He believed his patients were able to give “valid consent” during “lucid intervals.”<sup>255</sup>

This unbridled enthusiasm for the surgery eventually brought its fall from grace. An investigation in 1893 into the presence of a surgical ward at the State Hospital for the Insane in Norristown, Pennsylvania, opened to perform “bilateral oophorectomy,” as ovariectomy was otherwise known, concluded that the operation was “illegal... experimental [in] character...brutal and inhumane, and not excusable on any reasonable ground.” This report marked the beginning of the end of ovariectomy to treat mental disorders.<sup>256</sup> Leading gynecologists started to speak

out in opposition. By the end of the century, Battley’s operation was largely forgotten.

Like in the case of lobotomy, the medical world should have learned a crucial lesson from the ill-fated history of ovariectomy. Surgeons should have recognized the peril of hastily embracing new procedures with profound, life-long effects on vulnerable patients. Furthermore, it ought to have alerted doctors to the role of medical influence in shaping symptoms of patients, often women, who internalize doctors’ beliefs, causing them to manifest psychosomatic symptoms and seek surgical solutions. And yet, astonishingly, in the 21st century, we are once again observing another such event, one that bears a disconcerting resemblance to the ovariectomy blunder.

There are many striking parallels between the surgeons who removed women’s healthy ovaries as a treatment for mental distress in the 19th century and the WPATH doctors today who are advocating for surgeons to remove the healthy breasts and reproductive organs of teenage girls and young women also as a treatment for their mental distress.

While from the outset ovariectomy was horribly misguided, the surgeons at least began with a certain level of caution. The procedure was initially indicated for conditions such as menstrual madness, epilepsy, nymphomania, and masturbation, but later became the treatment for all forms of insanity, including for hysteria, the psychiatric epidemic of the age.

Sex-trait modification procedures for people who identify as transgender followed the same trajectory. Medical intervention was initially reserved for only the most persistent of gender dysphoria cases. However, when activists captured WPATH, hormonal interventions

251 Shorter, E. *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era*. Simon and Schuster, 2008: 221. <https://www.simonandschuster.ca/books/From-Paralysis-to-Fatigue/Edward-Shorter/9780029286678>.

252 MacCormac, W., & Makins, G. H. *Transactions of the International Medical Congress, Seventh Session, Held in London, August 2d to 9th, 1881*. Vol. 4: JW Kolckmann, 1881. <https://babel.hathitrust.org/cgi/pt?id=mdp.39015007091385&seq=315>.

253 Goodell, W. “Clinical Notes on the Extirpation of the Ovaries for Insanity.” *American Journal of Psychiatry* 38, no. 3 (1882). <https://sci-hub.ru/10.1176/ajp.38.3.294>.

254 *Ibid.* (n.243 p.256)

255 *Ibid.* (n.243 p.261)

256 *Ibid.* (n. 243 p. 262)

became the first line of treatment because psychotherapy to help the patient reconcile with his or her birth sex was deemed conversion therapy. As we have seen in the discussions in the WPATH Files, prolonged testosterone use in women leads to uterine atrophy and the need for a hysterectomy, with some opting to have their healthy ovaries removed along with their uterus. The medical attack on the reproductive organs of adolescent girls and vulnerable women in the 21st century may have added one more step along the way, but that doesn't make this any less of a medical crime.

An eerie echo of the past can be heard in the Identity Evolution Workshop, when, more than a century after the ovariectomy scandal ended, Ferrando discussed "early oophorectomy" with her fellow WPATH members. The WPATH-affiliated surgeon described explaining to young women that with "early removal of the ovaries" comes the need for lifelong hormone supplements for cardiovascular and bone health.

"So those are the things that we think about in this cohort of 20-year-olds in whom we're removing the ovaries," said Ferrando.

In fact, just like the ovariectomists of the past, Ferrando has no reliable science to guide her in treating these young patients. A 2019 review of the literature to support the practice of removing the healthy ovaries of young women who identify as men found the supporting evidence to be "lacking" and described an urgent need for research into the "metabolic and cardiovascular risk" to these female patients.<sup>257</sup>

The removal of ovaries from Victorian women did not alleviate their mental health issues, as their psychological struggles were not rooted in their ovaries. Similarly, the removal of healthy breasts and reproductive organs today often does not resolve the challenges faced by adolescent girls and vulnerable women, many of whom come to realize too late that their mental distress was related to

coexisting psychiatric disorders, autism, trauma, or difficulty accepting their emerging homosexual orientation.

Much like women in the 19th century who internalized the reflex theory narrative, fixating on their reproductive organs as the root cause of their mental distress and subsequently requesting ovarian removal surgeries, vulnerable women and girls in the 21st century are now embracing the narrative of the modern trans rights movement that tells them if they hate their female bodies, it is an indication of the need for surgical alteration. Once again, they are fixating on their reproductive organs, and this time their breasts too, as the source of their anguish and seeking a surgical solution.

In Shorter's analysis, the unwavering conviction that one needs a surgical procedure represents a psychosomatic symptom, wherein the patient coalesces their vague and troubling sensations into a fixed diagnosis. Victorian women, influenced by the prevailing reflex theory, perceived their various feelings of sadness and anxiety through this cultural perspective. They interpreted these symptoms as being an indication of unhealthy ovaries, and once convinced of this belief, they firmly believed that undergoing an ovariectomy would alleviate all their mental anguish.

Today, many teenage girls are interpreting their normal pubertal woes as a sign they are transgender because they are viewing their suffering through a cultural lens that teaches them that their distress is an indication that they were born in the wrong body and that sex-trait modification procedures are the only solution. Once they latch onto this explanation, they become preoccupied with the idea of removing their breasts and reproductive organs, firmly believing that these surgical procedures will alleviate all their emotional difficulties, bringing them health and happiness.

Thus, the WPATH members who endorse such thinking and facilitate teenage girls and young women in

257 Reilly, Z. P., Fruhauf, T. F., & Martin, S. J. (2019). Barriers to Evidence-Based Transgender Care: Knowledge Gaps in Gender-Affirming Hysterectomy and Oophorectomy. *Obstetrics & Gynecology*, 134(4), 714-717. <https://doi.org/10.1097/aog.0000000000003472>

altering their bodies based on entirely unfounded beliefs are akin to the gynecologists and psychiatrists of the 19th century who enabled the women seeking the medically unnecessary removal of their healthy ovaries.

Ovariectomy enjoyed the support of many of the most respected surgeons of the time, including J. Marion Sims, Lawson Tait, and Spencer Wells. This endorsement lent an aura of credibility to the procedure despite the absence of sound scientific justification for the removal of healthy organs. Today, the surgical removal of breasts and reproductive organs as a solution for a woman's psychological distress is supported by all significant American medical associations, even though these procedures likewise lack a solid foundation in scientific research.

Doctors who opposed ovariectomy were accused of being "wanting in humanity" and "guilty of criminal neglect of patients" when, in truth, the procedure was pseudoscientific, extremely risky, and entirely ineffective. Doctors who oppose the removal of healthy body parts as a cure for gender dysphoria are vilified in much the same way, facing accusations of transphobia and hate and the possible loss of their livelihood.

The surgeons removing healthy ovaries to cure mental illness lived in an age long before the development of evidence-based medicine and rigorous scientific standards. This was the Wild West of medicine, with scalpel-happy surgeons, many excited by the new possibilities opened up by the invention of anesthetics, trying out new surgical techniques with no oversight or regulation. It was only when the ovariectomists overstepped the mark by opening surgical wards in mental asylums that the practice drew widespread condemnation and was brought to an end.

But gender surgeons today have no such excuse for their unethical behavior. Today, we expect medical professionals to adhere to strict protocols. We expect randomized controlled trials and meticulous follow-up.

There are no such studies to prove that removing the healthy breasts and reproductive organs of teenage girls and young women is safe, ethical, and effective in relieving their mental distress.

A medical experiment based upon an untested article of belief was unacceptable in the 19th century. It is unforgivable today.

### Apotemnophilia

**A case study comparing the desire to have healthy limbs amputated with the desire to have surgically-created abnormal genitalia**

In 2000, a surgeon in Scotland made headlines when it was revealed that he had performed leg amputations on two men who were physically healthy but afflicted with a psychiatric condition known as apotemnophilia, or what is now more commonly referred to as body integrity identity disorder (BIID).<sup>258</sup>

In 1997, Dr. Robert Smith amputated the healthy lower leg of a man at Falkirk and District Royal Infirmary, and two years later, in 1999, Smith amputated the healthy leg of a second man.<sup>259</sup> He was set to amputate the leg of a third man, Dr. Gregg Furth, a New York child psychologist, when the hospital ethics board investigated his actions and ruled that the procedures were unethical. The NHS removed his funding, and Smith was banned from further mutilating healthy bodies.

Dr. Russell Reid, a psychiatrist based in London, had diagnosed the men with "apotemnophilia," a rare psychiatric condition characterized by an intense fixation on having healthy limbs amputated. Typically, this obsession focuses on one leg, although some patients express a desire to remove both legs, an arm, or occasionally specific fingers or toes. Paradoxically, those afflicted with this disorder assert that they do not feel complete with all four limbs or all ten digits, believing their true identity is that of an amputee. According to Dr. Reid,

258 "Surgeon Defends Amputations." BBC News, 2000, [http://news.bbc.co.uk/2/hi/uk\\_news/scotland/625680.stm](http://news.bbc.co.uk/2/hi/uk_news/scotland/625680.stm).

259 Dyer, C. "Surgeon Amputated Healthy Legs." [In eng]. *Bmj* 320, no. 7231 (Feb 5 2000): 332. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1127127/>.

traditional psychotherapy “doesn’t make a scrap of difference in these people.”<sup>260</sup>

Many researchers, including Reid, have noted the obvious parallel with transgenderism, or transsexualism as it was known during the early 2000s when the controversy surrounding Smith’s surgeries triggered a flurry of interest in this obscure psychiatric condition.<sup>261,262</sup>

The term apotemnophilia, literally “love of amputation,” was coined by the infamous Dr. John Money in the 1970s. Noting the erotic motivation of many, or perhaps most, of these patients, Money categorized the disorder as a paraphilia, or in other words, a sexual deviancy, recognizing that these individuals achieved sexual fulfillment by fantasizing about being an amputee, or indeed actually becoming one. Many apotemnophiles also suffer from what Money termed acrotomophilia, which is to be sexually attracted to amputees.

Smith described the two leg amputations he performed on his apotemnophile patients as being the most rewarding operations of his career and said he felt no regret at satisfying the men’s wishes.<sup>263</sup> He argued that the surgeries were life-saving, claiming that apotemnophiles will either attempt to perform the amputation themselves or go to extraordinary lengths to self-inflict injuries, such as with dry ice, guns, or chainsaws, in a desperate bid to force surgeons to amputate.<sup>264,265</sup>

Indeed, in 1998, 79-year-old Philip Bondy of New York paid \$10,000 to John Brown, a surgeon in Tijuana, to

have his left leg amputated. He died two days later of gangrene, and Brown was charged with second-degree murder. It was reported during Brown’s trial that Bondy wished to have his leg amputated to fulfill a “sexual craving.” Brown had lost his medical license in 1977 after three patients nearly died from sex-change surgeries he had reportedly performed in locations such as a garage and a hotel.<sup>266</sup>

Another case is that of a 55-year-old American man who amputated his own arm using a home-made guillotine.<sup>267</sup> Further examples can be found in the 2003 documentary *Whole*, which featured the stories of a Florida man who shot himself in the leg so that it would need to be amputated and that of a man from Liverpool, England who packed his leg in dry ice. The latter called his amputation a “body correction surgery.”<sup>268,269</sup> Smith also appears in the documentary, arguing that refusing to amputate a healthy limb is a violation of the Hippocratic Oath. “The Hippocratic oath says first do your patients no harm,” he said, before going on to explain that the real harm is to refuse to help such a patient, “leaving him in a state of permanent mental torment,” when all it would take for him “to live a satisfied and happy life” would be to amputate.

This unusual psychiatric disorder is not new. Since the late 1800s, there have been cases described in medical literature of men and women being sexually attracted to amputees or people with other disabilities, as well as people

260 “Complete Obsession.” BBC Home, 2000, [https://www.bbc.co.uk/science/horizon/1999/obsession\\_script.shtml](https://www.bbc.co.uk/science/horizon/1999/obsession_script.shtml).

261 Lawrence, A. A. “Clinical and Theoretical Parallels between Desire for Limb Amputation and Gender Identity Disorder.” [In eng]. *Arch Sex Behav* 35, no. 3 (Jun 2006): 263-78. <https://doi.org/10.1007/s10508-006-9026-6>.

262 Bailey, M. J., Hsu, K. J., & Jang, H. H. “Elaborating and Testing Erotic Target Identity Inversion Theory in Three Paraphilic Samples.” *Archives of Sexual Behavior* (2023/07/06 2023). <https://doi.org/10.1007/s10508-023-02647-x>. <https://doi.org/10.1007/s10508-023-02647-x>.

263 Elliott, C. “A New Way to Be Mad.” *Atlantic monthly* (Boston, Mass.: 1971) (12/01 2000): 73-84.

264 “Healthy Limbs Cut Off at Patients’ Request.” *The Guardian*, 2000, <https://www.theguardian.com/society/2000/feb/01/futureofthenhs.health>.

265 First, M. B. “Desire for Amputation of a Limb: Paraphilia, Psychosis, or a New Type of Identity Disorder.” [In eng]. *Psychol Med* 35, no. 6 (Jun 2005): 919-28. <https://doi.org/10.1017/s0033291704003320>.

266 “Ex-Doctor Tried in Amputation-Fetish Death.” *Tampa Bay Times*, 1999, <https://www.tampabay.com/archive/1999/09/29/ex-doctor-tried-in-amputation-fetish-death/>.

267 Dua, A. (2010). Apotemnophilia: ethical considerations of amputating a healthy limb. *J Med Ethics*, 36(2), 75-78. <https://doi.org/10.1136/jme.2009.031070>

268 Gilbert, M. “Whole.” 2003. <https://www.imdb.com/title/tt0429245/>.

269 Henig, R. M. “At War with Their Bodies, They Seek to Sever Limbs.” *New York Times* 22 (2005): F6. <https://www.nytimes.com/2005/03/22/health/psychology/at-war-with-their-bodies-they-seek-to-sever-limbs.html>.

who pretend to be disabled or wish to become disabled.<sup>270</sup> But it was the dawn of the Internet era that drew attention to this group of individuals with such unusual sexual interests, and online chat rooms provided a place for like-minded people to congregate and share their amputation fantasies and desires.

Online, they call themselves devotees, pretenders, and wannabes (DPWs). Devotees are non-disabled people who are sexually attracted to people with disabilities; pretenders are non-disabled people who act out having a disability, usually with the aid of crutches, wheelchairs and leg braces; and wannabes are people who actually wish to become disabled.

A 2005 study by Dr. Michael First of 52 sufferers of BIID found that the primary reason for desiring the amputation of a healthy limb was the feeling that it would “correct a mismatch between the person’s anatomy and sense of his or her ‘true’ self (identity).”<sup>271</sup>

Some examples of the answers study participants gave include: “[After the amputation] I would have the identity that I’ve always seen myself as,” and “I feel myself complete without my left leg...I’m overcomplete with it.” The most strikingly similar statement to the “born in the wrong body” narrative of today’s transgender rights movement was: “I felt like I was in the wrong body; that I am only complete with both my arm and leg off on the right side.”<sup>272</sup>

Despite a small amount of scientific literature to suggest that BIID sufferers benefit from having safe access to amputations, to our knowledge, there are no surgeons in North America, or indeed the developed world, willing to perform such extreme elective operations. Even in this day

and age, when WPATH-approved genital and breast amputations are commonplace and even performed on minors, the idea of amputating healthy limbs is reviled by most people.

In the WPATH Files, a discussion thread makes the obvious comparison between BIID and gender dysphoria, with an Australian clinician noting that it is “clear these individuals do display some characteristics similar to trans people.” However, not everyone inside WPATH agrees. Bowers was questioned on the topic in a 2022 documentary and denied any similarity between the two disorders, calling apotemnophilia “a mental diagnosis and a psychiatric condition” and describing those who seek amputation of a healthy limb as “kooky.”<sup>273</sup>

However, the similarities are clear. In the 2005 New York Times article with the headline, *At War With Their Bodies, They Seek to Sever Limbs*, Dr. First, author of the aforementioned 2005 study, compared the amputation of healthy limbs to sex-reassignment surgery. “When the first sex reassignment was done in the 1950’s, it generated the same kind of horror,” said First. “Surgeons asked themselves, ‘How can I do this thing to someone that’s normal?’ The dilemma of the surgeon being asked to amputate a healthy limb is similar.”<sup>274</sup>

But as First pointed out, the analogy falls short of being perfect. “It’s one thing to say someone wants to go from male to female; they’re both normal states,” he said. “To want to go from a four-limbed person to an amputee feels more problematic. That idea doesn’t compute to regular people.”

While there are many parallels with traditional sex-reassignment surgeries, including similarities between

270 Bruno, R. L. “Devotees, Pretenders and Wannabes: Two Cases of Factitious Disability Disorder.” *Sexuality and Disability* 15, no. 4 (1997/12/01 1997): 243-60. <https://doi.org/10.1023/A:1024769330761>. <https://doi.org/10.1023/A:1024769330761>.

271 First, M. B. “Desire for Amputation of a Limb: Paraphilia, Psychosis, or a New Type of Identity Disorder.” [In eng]. *Psychol Med* 35, no. 6 (Jun 2005): 919-28. <https://doi.org/10.1017/s0033291704003320>.

272 Ibid (n.271)

273 “What Is a Woman?”. 2022. <https://www.dailywire.com/videos/what-is-a-woman>.

274 Henig, R. M. “At War with Their Bodies, They Seek to Sever Limbs.” *New York Times* 22 (2005): F6. <https://www.nytimes.com/2005/03/22/health/psychology/at-war-with-their-bodies-they-seek-to-sever-limbs.html>.



apotemnophilia and autogynephilia,<sup>275</sup> which is a paraphilia that drives some men to seek medical sex changes, perhaps a closer parallel can be drawn with those who desire their healthy male or female genitals to be reconfigured into abnormal states such as nullification and bigenital surgeries, as well as those seeking to become eunuchs.

The surgeries described by Satterwhite and his devoted followers in the WPATH Files involve creating a type of body that does not exist in nature, in the same way that turning a four-limbed person into an amputee creates a type of body that is abnormal. This ought to generate a feeling of horror in any surgeon dedicated to the Hippocratic Oath, not to mention in all policymakers, insurance companies, and the general public at large.

The amputation of a healthy limb is viewed by most as a violation of the Hippocratic Oath. Still, it is at least a relatively straightforward surgical procedure with few complications and risks, and BIID is also a recognised psychiatric disorder. The same cannot be said for the amputation of healthy genitalia or the creation of a second set of genitals in the service of meeting body modification goals and experiencing “gender euphoria.” As well, an apotemnophile who undergoes an amputation can get a prosthesis that functions reasonably well, but there is no such prosthesis that can replace an amputated penis.

In the nullification surgeries offered by Satterwhite and discussed in the WPATH Files, a surgeon amputates the healthy genitalia of a man to create a smooth, sexless body. This pointless form of extreme body modification not only drastically impacts the man’s sexual function and destroys his ability to father children, but it also impacts his urinary and endocrine system, two vitally important bodily systems with far-reaching implications for his future health and well-being.

Then there are the “bigenital” surgeries, such as the “phallus-preserving vaginoplasty” and “vagina-preserving phalloplasty,” procedures also discussed in the WPATH

Files and performed by WPATH surgeons like Satterwhite. These surgeries to create a non-functional second set of genitals come with an extremely high risk of complications. Furthermore, such radical cosmetic surgeries will have a dramatic impact on the patient’s health and ability to form long-term romantic partnerships.

Thus, when we compare the detrimental impact that nullification and bigenital surgeries have on a person’s sexual identity, which is an intrinsic part of their humanity, coupled with the risks that such surgeries entail, it is clear that the medical crime committed by WPATH-affiliated surgeons is far greater than that of Dr. Robert Smith in Scotland in the 1990s. The NHS Ethics Committee rightly banned Smith from performing further amputations, and we call for WPATH’s consumer-driven gender-affirming care to be banned by ethics committees in every town and city across the US and globally.

Another important difference is in the response from the popular press. When the amputations performed by Dr. Smith were revealed, reporting was largely negative. Falkirk and District Royal Infirmary’s decision to prevent Smith from carrying out further amputations was in part related to the negative publicity. However, in today’s media landscape, non-binary identities are celebrated and gender-affirming care is portrayed as “life-saving.” Articles rarely describe the specifics of genital surgeries, but the overall message is consistently positive in today’s mainstream press. This helps to increase awareness of these identities and generates desire for genital surgeries. If, in the 1990s, the press had reported favorably about people with innate amputee identities and framed the amputations as a human right and life-saving, it is certainly possible that society would have witnessed an increase in people identifying as amputees and seeking elective amputations.

Both people desiring limb amputation and people desiring abnormal genitalia seek extreme elective surgery to align their bodies with their subjective identity. But, the

275 Lawrence, A. A. “Clinical and Theoretical Parallels between Desire for Limb Amputation and Gender Identity Disorder.” [In eng]. *Arch Sex Behav* 35, no. 3 (Jun 2006): 263-78. <https://doi.org/10.1007/s10508-006-9026-6>.



origins of that internal sense of self appear to be very different. Apotemnophiles often report seeing an amputee in childhood and, from that moment on, become obsessed with the idea of being an amputee. For many, this obsession then became sexual at the onset of puberty. Similarly, autogynephiles report an obsession with cross-dressing in childhood, beyond the typical dress-up most children engage in, and feeling a thrill of excitement coupled with shame and embarrassment.<sup>276</sup> The sexual element likewise only began at puberty. Even the “eunuch-identified” men described in the bizarre WPATH 2022 Eunuch session were disproportionately likely to have grown up on farms and, therefore, to have witnessed animals castrated. Johnson and Irwig even borrowed language from online apotemnophile communities, describing the men seeking “eunuch calm” as “wannabes.”<sup>277</sup>

But those seeking nullification and bigenital surgeries will never have come across people with no genitals or both sets of genitals in their childhood because such a type of person did not exist until WPATH’s genre of gender medicine came into being. A parallel cannot be drawn with “intersex” individuals or people with differences of sexual development (DSDs), as such conditions are now known. Individuals with DSDs do not have no genitals or both sets of genitals, and many within the intersex community find the comparison deeply offensive.

While it is not possible to transform a man into a woman by inverting his penis, nor a woman into a man by amputating her breasts and creating a pseudo-penis out of her forearm, such extreme surgeries are at least an attempted remedy, albeit a very misguided one, for a recognized psychiatric disorder. WPATH’s non-binary surgeries lack any medical justification and are merely extreme consumer-driven body modifications.

### Engineering Children’s Height With Hormones

**A case study comparing the past scandal of pediatric endocrinologists attempting to correct the height of tall**

### **girls and short boys with today’s scandal of pediatric endocrinologists attempting to correct gender-nonconformity in children**

In the 1950s, pediatric endocrinologists embarked upon an experiment to correct the height of abnormally tall and short children using hormones. This was in the early days of endocrinology when endocrinologists had the air of miracle workers. With the discovery of insulin, this new and exciting branch of medicine had brought diabetics back from the brink of death, and a few short years later, used cortisone to give mobility to crippled arthritics.

So when synthetic estrogen (DES) was developed, and scientists found a way to extract human growth hormone (hGH) from the pituitaries of cadavers, pediatric endocrinologists got swept up in the excitement of discovery and turned their attention to “correcting” the height of tall girls and short boys.

Initially, this experiment was confined only to those suffering from medical conditions such as gigantism and dwarfism. But, soon, endocrinologists broadened their patient pool to include healthy children who didn’t measure up to the height standards of the day.

Despite imprecise height prediction methods, a paucity of research into the psychosocial benefits, and a complete absence of evidence about long-term safety and effectiveness, thousands of healthy children were subjected to this treatment. The treatments weren’t lacking opposition, though, with some questioning whether abnormal height was a medical problem or just a social impediment.

The media played a role in spreading the word about this new and exciting solution to the woes of being either too tall or too short. Australian pediatrician Norman Wettenhall spearheaded the experiment to correct the height of girls destined to be tall. In 1964, Australian media uncritically reported his success in treating twenty-five tall girls. The Sydney Sun ran a front-page story featuring “two of Australia’s growth-controlled girls,” who were described

276 Lawrence, A. A. *Men Trapped in Men’s Bodies: Narratives of Autogynephilic Transsexualism*. Springer Science & Business Media, 2012.

277 Ibid (n.221)

as “happy, pretty teenagers who have been prevented from growing embarrassingly tall” by estrogen therapy.<sup>278</sup> This article and others neglected to mention the often debilitating side effects of the treatment, which included weight gain, depression, intense nausea, ovarian cysts, and spontaneous lactation. What ensued was a surge of parents seeking treatment for their daughters, many of whom were mothers who were unhappy with their own tall stature.

While Wettenhall was conducting his experiment in Australia, a group of researchers in the US, headed by Alfred Wilhemi, a chemist at Yale, were crudely processing pituitary glands harvested from morgues, grinding the glands in a blender and then drying them into a powder that would later be injected into short children, the majority of whom were boys. The Food and Drug Administration (FDA) allowed this experiment, and the NIH established and funded a national pituitary collection program. An unlikely coalition of parents of short children and commercial airline pilots worked together to gather pituitaries from coroners and fly them, stored in acetone and on dry ice, to the processing plant.<sup>279</sup>

But then, in 1984, tragedy struck. Those who had been treated with hGH started to die of Creutzfeldt-Jakob disease (CJD), a devastating fatal illness caused by a prion that had gone undetected during processing.<sup>280</sup> It was discovered that fears that hGH injections could spread CJD had been ignored for years.<sup>281</sup> Pituitary-derived hGH was swiftly removed from the market and replaced by a

synthetic form, although many pediatric endocrinologists initially thought the ban was too severe and an overreaction. Some parents even acquired pituitary-derived hGH from other sources after being informed of the risk.<sup>282</sup>

There was now unlimited supply of synthetic human growth hormone, and some pediatric endocrinologists began experimenting with a combination of puberty blockers and hGH to give the child more time to grow.

Genentech, the drug company that won FDA approval for synthetic hGH, set about expanding its off-label use to treat healthy children of short stature, financing a journal, funding studies on growth, sponsoring symposiums, courting pediatric endocrinologists and funding height screening programs in American schools.<sup>283</sup> This eventually led to Genentech becoming the first drug company in history to face criminal prosecution by the FDA for illegally promoting off-label, resulting in one of the largest financial penalties ever paid in the industry.<sup>284,285</sup>

At the same time, the harmful effects of estrogen therapy were being exposed, with links to cancer and disorders of the reproductive system.<sup>286</sup> In 1976, the New York Times ran an article downplaying the dangers, quoting a pediatric endocrinologist who claimed the therapy was safe for tall girls because they typically took the hormone for a shorter period of time and another saying, “the choice is to be overly tall or to take a risk that is almost nonexistent.”<sup>287,288</sup>

278 Cohen, S., & Cosgrove, C. *Normal at Any Cost: Tall Girls, Short Boys, and the Medical Industry's Quest to Manipulate Height*, 32. Penguin, 2009.

279 *Ibid.* (n.278 p.78)

280 “National Hormone & Pituitary Program (Nhpp): Information for People Treated with Pituitary Human Growth Hormone.” National Institute of Diabetes and Digestive and Kidney Diseases 2021, <https://www.niddk.nih.gov/health-information/endocrine-diseases/national-hormone-pituitary-program>.

281 *Ibid.* (n. 279 p.275)

282 *Ibid.* (n. 279 p.143)

283 *Ibid.* (n.279 ch.8)

284 Conrad, P., & Potter, D. “Human Growth Hormone and the Temptations of Biomedical Enhancement.” *Sociology of Health & Illness* 26, no. 2 (2004): 184-215. <https://doi.org/10.1111/j.1467-9566.2004.00386.x>.

285 *Ibid.* (n.279 p.188)

286 Herbst, A. L., Ulfelder, H., & Poskanzer, D. C. “Adenocarcinoma of the Vagina.” *New England Journal of Medicine* 284, no. 16 (1971): 878-81. <https://doi.org/10.1056/nejm197104222841604>. <https://dx.doi.org/10.1056/nejm197104222841604>.

287 Ziel, H. K., & Finkle, W. D. “Increased Risk of Endometrial Carcinoma among Users of Conjugated Estrogens.” [In eng]. *N Engl J Med* 293, no. 23 (Dec 4 1975): 1167-70. <https://doi.org/10.1056/nejm197512042932303>.

288 “The Use of Estrogen as a Growth Inhibitor in over-Tall Girls Is Being Questioned.” *The New York Times*, 1976, <https://www.nytimes.com/1976/02/11/archives/the-use-of-estrogen-as-a-growth-inhibitor-in-overtall-girls-is.html>.

However, this turned out to be false. An investigation into the Tall Girls scandal began in 2000. Researchers tracked down hundreds of women and found higher rates of infertility,<sup>289</sup> and increased risk of endometriosis. The researchers saw cancers in the group as well, but due to the small sample size, they couldn't conclude the effects of the treatment on cancer risk.<sup>290</sup>

As well, while short-term follow-up studies<sup>291,292</sup> had shown high rates of satisfaction in the girls who had undergone treatment, the investigation in 2000 revealed that 99.1% of the women who had not received treatment were happy they hadn't taken the hormone, compared to a regret rate of 42.1% for those who had, with the researchers concluding that 56% were "less than satisfied."<sup>293</sup> Many of the parents expressed profound guilt at what they had done to their daughters.

While the tall girls were still dealing with fertility issues and disorders of the reproductive system, and those treated with pituitary-derived hGH were still living with a potential death sentence hanging over their heads, the field of pediatric endocrinology moved on to its next reckless experiment, once again using hormonal interventions to mold children into gender-stereotype norms. This time, their attempt involved a whole rewrite of what it means to be human and a complete disregard for biological reality. However, the new adventure was eerily similar to its predecessor.

At the center of both scandals, there are healthy children who are different, who don't measure up to what is considered "normal" for the culture of their particular time and place, and there is a medical world willing to

embark upon an experiment to engineer normality. Gender nonconformity is no more a medical condition than being taller or shorter than the average height. Of note, in both scandals, adults who are unhappy with aspects of their appearance are the ones calling for children to be experimented on.

As well, there are off-label drugs being prescribed to healthy children without any knowledge of the drugs' safety, effectiveness, or benefits. However, the height-manipulation therapy experiment occurred long before the development of evidence-based medicine when it was common for doctors to test out ideas on patient groups without prior controlled testing. Neither for DES nor hGH were there any controlled trials or long-term follow-up studies before the drugs were rolled out for widespread use, but this was normal for the era.

It is the same for the puberty suppression experiment, which was rolled out into general medical practice based on the questionable results of a deeply flawed study of just 55 adolescents, with psychological data only available for 32 participants. This is reminiscent of Wettenhall's claims of success with just 25 tall girls, which led to the widespread adoption of estrogen therapy to correct height.

In the original Dutch paper, sponsored by Ferring Pharmaceuticals, a maker of puberty blockers, de Waal and Cohen-Kettenis even discuss the opportunity to "manipulate growth." Regarding height, the researchers point out that while a natal female's growth spurt will be hampered, the fusion of the growth plates will also be delayed. "Since females are about 12 cm shorter than males, we may intervene with growth-stimulating

289 Venn, A., Bruinsma, F., Werther, G., Pyett, P., Baird, D., Jones, P., Rayner, J., & Lumley, J. "Oestrogen Treatment to Reduce the Adult Height of Tall Girls: Long-Term Effects on Fertility." *The Lancet* 364, no. 9444 (2004): 1513-18. [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(04\)17274-7/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(04)17274-7/fulltext).

290 Ibid (n.279 p.345)

291 Crawford, J. D. "Treatment of Tall Girls with Estrogen." *Pediatrics* 62, no. 6 (1978): 1189-95. <https://doi.org/10.1542/peds.62.6.1189>.

292 De Waal, W. J., Torn, M., De Muinck Keizer-Schrama, S. M., Aarsen, R. S., & Drop, S. L. "Long Term Sequelae of Sex Steroid Treatment in the Management of Constitutionally Tall Stature." *Archives of Disease in Childhood* 73, no. 4 (1995): 311-15. <https://doi.org/10.1136/adc.73.4.311>. <https://dx.doi.org/10.1136/adc.73.4.311>.

293 Pyett, P., Rayner, J., Venn, A., Bruinsma, F., Werther, G., & Lumley, J. "Using Hormone Treatment to Reduce the Adult Height of Tall Girls: Are Women Satisfied with the Decision in Later Years?" *Social Science & Medicine* 61, no. 8 (2005/10/01/ 2005): 1629-39. <https://doi.org/https://doi.org/10.1016/j.socscimed.2005.03.016>.

treatment in order to adjust the female height to an acceptable male height,” they theorized at the time.<sup>294</sup>

The girls who were given DES experienced high rates of fertility issues many years later and an increased risk of endometriosis. These side effects were not foreseen by the endocrinologists who gave the hormone to these previously healthy girls.

It is possible, but surely unlikely, that the Dutch researchers who first embarked upon the adolescent sex-trait modification experiment also did not foresee the impact the treatment would have on the fertility and sexual function of their patients. However, the WPATH documents reveal that gender-affirming medical and mental health professionals today are well aware of the detrimental impact of puberty blockers and hormones on this important aspect of their young patients’ lives. From the discussions about vaginal atrophy as a result of prolonged testosterone use and descriptions of natal males having erections that feel like “broken glass,” to Bowers’s comments about natal males facing a lifetime of being infertile and anorgasmic, the documents clearly show that WPATH members know that the cross-sex hormone therapy their professional association endorses negatively affects a patient’s fertility and sexual function.

Just as Wilhemi and his fellow researchers did not anticipate that their treatment might pose a potential threat to the lives of their previously healthy patients, the Dutch researchers likewise did not foresee that suppressing puberty would result in the tragic death of one of the original study participants.<sup>295</sup> Like their predecessors administering contaminated hGH to healthy children, gender doctors had been aware of what Bowers refers to in the files as “problematic surgical outcomes” since at least 2005, but this was not enough to halt the experiment.<sup>296</sup>

Also reminiscent of the CJD crisis, the anecdote in the WPATH Files about the natal female who appears to have died of liver cancer brought on by prolonged testosterone use, as well as the Lancet case study of the 17-year-old with liver cancer, raise serious concerns. Just as the CJD nightmare didn’t surface until decades after the children had been treated, we may face another such catastrophe in the coming years as the risks of prolonged testosterone use in females begin to manifest.

In both scandals, there is a lack of good quality long-term research. During the height-modification scandal, clinicians conducted short-term follow-ups and reported high satisfaction rates. However, follow-up studies done before the women had reached the age that they might start to regret compromising their fertility have only limited worth. The long-term follow-up study conducted in 2000 found much higher rates of regret and dissatisfaction among the women.

There is the same lack of adequate long-term data for the hormonal interventions for adolescent sex-trait modification. Today’s experiment has a much greater detrimental impact on the young participants. Discussions in the files show that WPATH is aware that this treatment protocol is creating a generation of sexually dysfunctional young people.

Many of the short-term studies with reported high patient satisfaction rates are cited by gender-affirming clinicians as proof that sex-trait modification procedures are beneficial. But these are just as inadequate as the short-term studies during the height-modification scandal. For the data to be worthwhile, gender doctors need to follow up with their patients long into adulthood, when the true impact of sacrificing their fertility and sexual function is felt. But we are already seeing a trend similar to the tall girls

294 Ibid (n.157)

295 Ibid (n.74)

296 “Consensus Report on Symposium in May 2005.” gires, 2005, <https://www.gires.org.uk/consensus-report-on-symposium-in-may-2005/>.

experiment: the longer the follow-up period, the higher the regret rate for sex-trait modification interventions.<sup>297,298</sup> The preliminary findings of the Dutch long-term follow-up already indicate that fertility regret is significant.<sup>299</sup>

During inquiries into the CJD tragedy, a British court found that the UK Department of Health should have taken action in the summer of 1977 after warnings about CJD contamination were sounded, and an Australian investigation set the cut-off date at 1980. It's difficult to pin down exactly when gender-affirming doctors should have been aware that their puberty suppression experiment was causing harm. Very early on, it was noted that all, or almost all, children were progressing to irreversible cross-sex hormones,<sup>300</sup> and the “problematic surgical outcomes” were recorded in scientific literature as early as 2008.<sup>301</sup> However, a firm line can be drawn with the findings of Sweden, Finland and England's systematic reviews in 2019 and 2020.<sup>302,303,304</sup> Each of these pre-dated the comments made by Bowers in the forum and those of the panelists in the Identity Evolution Workshop.

One of the most striking differences between the two scandals is the impact of the therapy on the young person's future chance of forming long-term romantic partnerships. The parents signing their children up for height-modification hormone therapy did so out of the well-intentioned belief that it would increase the chances that their children would find a romantic partner, lasting love, and marriage.

Conversely, the parents signing their children up for

today's sex-trait modification hormone therapy don't seem to consider the fact that they are potentially ruining their child's future ability to form intimate relationships. Or, more likely, they do consider it, but they are coerced into agreeing by the transition-or-suicide lie that gender-affirming medical and mental health professionals tell reluctant parents.

The length of time the young people were to take hormones is also vastly different. For the height-modification experiment, the children could be on hormones for years, but as soon as they reached their final adult height, treatment immediately stopped. WPATH advocates for pediatric endocrinologists today to turn adolescents into lifelong medical patients, dependent on wrong-sex hormones for the rest of their lives, without any evidence that this treatment protocol is safe.

The clinicians in the 1950s and 1960s couldn't foresee a world where being tall would be socially acceptable for women and even admired, or the possibility that very tall or very short adults could develop resilience to conquer their perceived social disadvantage. Today, WPATH members cannot foresee their adolescent patients growing up, reconciling with their birth sex and no longer identifying as transgender, but the ever-growing number of detransitioners suggests this is not a rare occurrence. However, the young people having their bodies permanently altered by WPATH-influenced clinicians are not able to turn back the clock and undo the damage.

- 297 Hall, R., Mitchell, L., & Sachdeva, J. “Access to Care and Frequency of Detransition among a Cohort Discharged by a Uk National Adult Gender Identity Clinic: Retrospective Case-Note Review.” *BJPsych Open* 7, no. 6 (2021). <https://doi.org/10.1192/bjo.2021.1022>. <https://dx.doi.org/10.1192/bjo.2021.1022>.
- 298 Boyd, I., Hackett, T., & Bewley, S. “Care of Transgender Patients: A General Practice Quality Improvement Approach.” *Healthcare* 10, no. 1 (2022): 121. <https://doi.org/10.3390/healthcare10010121>. <https://dx.doi.org/10.3390/healthcare10010121>.
- 299 Ibid (n.48)
- 300 Ibid (n.294)
- 301 Cohen-Kettenis, P. T., Delemarre-van de Waal, H. A., & Gooren, L. J. “The Treatment of Adolescent Transsexuals: Changing Insights.” [In eng]. *J Sex Med* 5, no. 8 (Aug 2008): 1892-7. <https://doi.org/10.1111/j.1743-6109.2008.00870.x>.
- 302 “Gender Dysphoria in Children and Adolescents: An Inventory of the Literature.” Swedish Agency for Health Technology Assessment and Assessment of Social Services, 2019, <https://www.sbu.se/en/publications/sbu-bereder/gender-dysphoria-in-children-and-adolescents-an-inventory-of-the-literature/>.
- 303 “Lääketieteelliset Menetelmät Sukupuolivariaatioihin Liittyvän Dysforian Hoidossa. Systemaattinen Katsaus.” *Summaryx*, 2019, <https://palveluvalikoima.fi/documents/1237350/22895008/Valmistelumuistion+Liite+1.+Kirjallisuuskatsaus.pdf/5ad0f362-8735-35cd-3e53-3d17a010f2b6/Valmistelumuistion+Liite+1.+Kirjallisuuskatsaus.pdf?t=1592317703000>.
- 304 Ibid (n.160)

## CONCLUSION

As this report has shown, WPATH is not a medical organization. It is not engaged in a scientific quest to discover the best possible way to help vulnerable individuals who are suffering from gender-related distress. Instead, it is a fringe group of activist clinicians and researchers masquerading as a medical group, advocating for a reckless hormonal and surgical experiment to be performed on some of the most vulnerable members of society.

It would be criminal for a surgeon to sever the spinal cord of a person who identified as a quadriplegic or to blind a sighted patient who identified as blind. It is just as unethical to destroy healthy reproductive systems and amputate the healthy breasts and genitals of mentally unwell people. To do so without first even attempting to help the person overcome their mental illness, without realistically preparing the individual for the grueling post-op period or warning of the life-long negative effect that the procedures will have on their long-term health and ability to form intimate relationships amounts to medical negligence of the highest order.

Thus, there can be no doubt that we are currently witnessing one of the greatest crimes in the history of modern medicine. The scandal of WPATH's gender-affirming care combines all the elements of the four past medical misadventures outlined in our case studies.

Doctors cannot be trusted to regulate themselves. They, too, are human and possess the same inherent biases and vulnerabilities as the rest of us. This is especially true when groupthink takes hold and dissent is silenced. When a doctor stakes his or her reputation on a given treatment, it can lead to powerful conflicts of interest and confirmation bias, preventing even the most well-intentioned and competent physician from seeing the obvious harm being inflicted on patients. Bowers's claim in the New York Times, that the field of transgender medicine is "every bit as objective- and outcome-driven as any other specialty in medicine," demonstrates how blind WPATH's

leadership is to the reality of the organization's unethical approach to medicine.

We have regulatory bodies to maintain ethical standards, and we therefore call on medical ethics boards across the US and the rest of the world to conduct urgent, unbiased, transparent, and rigorous reviews of the sex-trait modification interventions WPATH endorses. We also call on the APA, the AMA, the AAP, and The Endocrine Society to set politics aside and condemn the pseudoscientific, unethical medical practices of WPATH.

Furthermore, we call upon the US government to launch an official non-partisan inquiry into how an organization with such disregard for medical ethics and the scientific process was ever granted the authority to establish global standards of care in a field of medicine. We advocate for this drastic action due to the unwarranted prestige, undue influence, and resulting danger posed by WPATH.

WPATH serves no purpose, contributes nothing beneficial to the field of gender medicine, and leads medical and mental health professionals astray. Several European nations have already abandoned the group's guidelines, indicating the extent to which WPATH has become obsolete.

Political activism and medicine should never mix. An organization in pursuit of political goals is one not in pursuit of patient health. The WPATH Files contain abundant evidence that the organization is an activist group, not a scientific one. From the Alberta professor stating that trans health care is about challenging cisnormativity to Satterwhite and his supporters ignoring the ethical concerns of non-binary surgeries and focusing on the importance of using politically correct language, it is clear that WPATH prioritizes politics over science.

The medical world self-corrects by open discussion, scientific debate, and diligent investigation. None of these factors is present within the WPATH Files. Instead, there is political discourse and policing of language. When one



clinician posted a study about detransitioners, WPATH's president cautions that "acknowledgment that de-transition exists to even a minor extent is considered off limits for many in our community." Given the complexity of gender medicine, the controversy surrounding the treatments, and the drastic, life-altering effects of the hormonal and surgical interventions endorsed by WPATH, it is especially disconcerting that the Ontario family physician was the lone dissenting voice in all the files.

A medical organization that cannot face up to the devastating harm its treatments are causing is a danger to the patients it claims to serve. The unwillingness to acknowledge the victims of this medical scandal, the refusal to recognize the growing body of evidence showing that the risks of gender-affirming care greatly outweigh any supposed benefit, and the extreme beliefs of many of its members indicate that WPATH will never be able to correct its course. The internal communications demonstrate that the organization is corrupt to its core.

Currently, lawmakers, judges, insurance companies,

and public health providers are duped into trusting WPATH's guidelines as a result of the broken chain of trust. These stakeholders are not aware that the political activists within WPATH are promoting a reckless, consumer-driven transition-on-demand approach to extreme body modification, even for minors and the severely mentally ill. It is for this reason that we believe the medical world must reject WPATH's guidelines.

Gender dysphoria is a complex psychiatric condition, and there is no easy answer as to the best way to ease the pain of those afflicted. It is beyond the scope of this report to attempt to find such a solution. However, it is possible to state with unequivocal certainty that the World Professional Association of Transgender Health does not advocate for the best possible care for this vulnerable patient cohort, and the detrimental impact of WPATH's actions over the past two decades has rendered the organization irredeemable. It is now imperative to usher in a new era in gender medicine, one that prioritizes the health and well-being of patients as its foremost objective.



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The WPATH Files appear in full below. We have organized the files for accessibility, but we have not edited, removed, or added any material. Dates are included when available, and all discussions occurred within the last four years. Members’ names are redacted, except in the case of the WPATH president, surgeons, and other prominent members. The files are unedited and nothing has been removed or added.

1) GENDER AFFIRMING SURGERY FOR MINORS

a) *WPATH* members discuss transition surgery for a 14-year-old

DISCUSSION

**14 years old trans female wants Gender Affirming Surgery**

829 Discussion Views  
3 Responses

Hello my dear Colleges, I would like to know how to proceed on a 14 years old trans female who started transition since she was 4. She wants to have Gender Affirming Surgery MtF and her parents are supporting her decision, But I have never done this on such a young patient.  
What are your recommendations for this case???

Submit

**Christine N. McGinn**

As background, I have performed about 20 vaginoplasties in patients under 18 over the past 17 years. I currently am battling my hospital for the ability to continue to do so in certain cases where I feel it is sound medical practice based on the situation and the patient. I have never been sued. None of those patients have regretted their decision that I am aware of. Not all of these vaginoplasties had perfect outcomes. The majority of them did fantastic. The ones who had trouble usually had trouble following the dilation schedule and had vaginal stricture. Patients over 18 can have the same dilation difficulties. Even when patients had difficulties they did not regret surgery.

That said, I feel we need to be together on this topic as a professional society. So my advice is tread lightly here. I know that hospitals are more commonly banning under 18 surgeries as I hear desperate stories in my patients and from many of my peers I have queried. The ability to get surgery in the US before 18 is very limited because hospitals are preventing it and the aggressive attacks from the right have had a chilling effect on surgeons willingness.

I think we need a strong message that "gender surgeries" should not be lumped together and each specific surgery has its own discussion. For example a trach shave is not the same as Vaginoplasty.

I think we need to reject the argument that consent is impossible in a minor. My hospital performs all kinds of surgeries on minors without issue; they are singling these out because it is politically convenient.

I think we should strive for consensus regarding what a consent should look like for each of these surgeries.

Specific to Vaginoplasty, I have better success with dilation when the patient is at late 16 or 17. I would discourage Vaginoplasty surgery prior to that. In dealing with my hospital, I have offered to limit the under 18 surgery to 17. There is practical reason for this. Many of the bad outcomes are a direct result of rushing to get surgery before heading off to college/university. There are too many stressors in college that limit patients ability to dilate. For well prepared patients, I feel the ideal time in the US is surgery the summer before their last year of high school. I have heard many other surgeons echo this.

I also welcome appointments for the sole purpose of fact finding. I think it would be great for your 14 year old to hear about the surgery and what recovery is like and about hair removal if you require that. Conversations about surgery can be helpful at younger ages so that the parents and children can get their questions answered and navigate surgery and hormones as they relate to surgery. Penoscrotal hypo plasma is also an important topic to discuss early.

Good luck with this challenging case and good for you to seek information from others!!

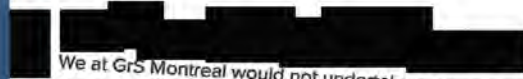
Comment



Marci L. Bowers [REDACTED]

i would not do it... tissue too immature. dilation routine too critical. Age 16 is the youngest i've EVER done though feel sometime before the end of high school does make some sense in that they are under the watch of parents in the home they grew up in. currently our standard is 18, though do agree this number is arbitrary. decision should be individual based on maturity.

Comment



We at GrS Montreal would not undertake a surgery at 14. Genital surgery is delayed until the patient reaches 18.

Comment

2) MENTAL HEALTH CONCERNS

a) WPATH members discuss amputation for patients with body integrity identity disorder (BIID)





b) WPATH members discuss trauma and dissociative orders in trans patients

## Trauma and the Presence of Dissociative Disorders in Trans Patients

Trauma is common among trans clients. Nonetheless, I was surprised to find that several of my clients met criteria for dissociative disorders, primarily OSDD. I was wondering if other people have noticed incidents of OSDD and DID among their trans clients, and whether there has been any difficulty with the system agreeing to transitioning medically, especially given that not all the alters have the same gender identity?

September 3, 2021

Submit

Hi [REDACTED] I do not know the statistics or correlation between gender variance or neurodiversity and DID/OSDD...but I still find it uncommon overall in my own practice. I think I believe I have had a total of 3 in the past five years. One had a conflict with gender ID/presentation within the system - was still working on navigating this when they switched to EMDR - I do not know outcome. I find it to be like family work :) One had an all male system but chose to not transition at all (AFAB), even socially. One I just cannot seem to recall but I believe they dropped out of treatment abruptly d/t family pressures. I do not believe I have ever been asked to write a letter for someone in this situation. Or if I did, the system was in agreement with medical transition - or they came to an understanding within themselves. My suspicion is that some are closeted about this aspect in the fear it will interfere with medical transition.

September 12, 2021

This is a really great point! I haven't seen any recent studies on the correlation between a positive transgender identification and dissociative disorders- but professionally (and personally) I have noted a high incidence of dissociative disorders amongst the community throughout both my interactions as both a social services worker and my personal connections within the community. (Yet, I will be the first to admit & challenge that my own experiences might be different, as an open transmasculine social work professional, I can be afforded a lot of trust from my predominantly LGBTQIAS2+ Clientele on that fact alone- thereby impacting the information I receive- as I have had numerous clientele presenting with OSDD/DID symptoms who admit that they didn't speak on the issue often with other social services members, fearing that this in conjunction with their perceived 'gender deviance' would make them appear 'too crazy'). I have found that with a diagnosis of OSDD/DID, clientele worry that they will be denied gender affirming medical procedures/interventions- a fear that has led to several of my trans clientele over the years, turning to black market gender affirming procedures/medication rather than attempting to go through the medical system.

September 15, 2021

Comment

I have felt good about calling it complicated PTSD, since trauma is the etiology and employers and spouses understand that as a mechanism. Also, I don't think surgeons would blink at that as much as DID. I would love to talk more offline as somehow I have 12 clients with DID and it seems there is a significant and important connection with gender diversity that I am now trying to screen for before starting hormones. This is because I have 2 such folks who after several years on hormones felt their decision to start hormones was colored by trauma and DID and now after more therapy and understanding wish they had dug deeper before starting hormones. This is a very small percentage but worth exploring in therapy prior to hormone approval.


September 26, 2021



[REDACTED]

With one client who had DID we worked on all alters giving consent to HRT before it was started. They had alters who were both male and female gender and it was imperative to get all alters who would be effected by HRT to be aware and consent to the changes. Ethically, if you do not get consent from all alters you have not really received consent and you may be open to being sued later, if they decide HRT or surgery was not in their best interest.

October 7, 2021

 Comment

[REDACTED]

Thanks [REDACTED] for raising this issue and for those who have responded.

I too have seen a relatively small but significant number of trans and gender diverse clients with DID; and have noticed an increase in the number of new clients with dissociative experience (cPTSD).

I am curious about how we collectively - clients, therapist, treating

physicians & surgeons - adequately respond to this. It concerns me that some individuals may not disclose for fear of denied access to treatment, yet I am also concerned about transition (even when all known parts/alters agree).

Is there a way those of us working with dissociative clients could work together to more fully describe the scope and approaches in this area?

October 17, 2021



Hi [REDACTED]

I wondered if anyone responded to your request of working together in this area. I think you've raised this multiple times over the years. Gender health specialists really need to be working with clinicians with extensive experience in dissociation. I know these are both areas where you've worked extensively. I do not know if this new platform has the ability to create small groups, but if we could set up some sort of ongoing discussion on this topic it would be great.


November 11, 2021

[REDACTED]  
Hello,

Would it be worthwhile to consider looking at the International Society for the Study of Trauma and Dissociation (<https://www.isst-d.org/>) and beginning a dialogue to see if there is something that can be looked at as a collective?

I have a large number of clients who have DDNOS/DID/c-PTSD or have dissociation on some level as part of their experience who are transitioning and are trans or gender diverse. I use EMDR in my practice and I have found that ISST-D to be helpful though not as inclusive as I would like. Would this be worth consideration and a potential way to define more approaches or interventions that are used/that could be talked about in this context?

October 17, 2021

 Comment

[REDACTED] I am grateful for your response, and I hope it prompts more discussion about this issue. Personally, I am pursuing training in treating trauma and dissociative disorders, as well as consulting with a specialist in these disorders, but it is difficult, and dissociative disorders are, after all, covert. I too would love to hear from others how we as clinicians and as clinical support teams can work with these clients to honor their gender identity and their fractured ego identities.

October 18, 2021

The concepts of adult autonomy and competency are important here. I work with people experiencing dissociative disorders and with people who are figuring out their gendersex identity and with people who are experiencing both. These questions don't come up when a heterosexual cisgender person, who can afford it, requests lip plumping procedures nor when a person living with DID requests such a procedure. Also, autonomy and competency questions arise in the case of an alter personality part or EP commits a crime. This conversation is important and, as others have mentioned, there is no one answer that applies to all.

October 21, 2021

Comment

This may not be exclusively for dissociative disorders, but in terms of different parts of the self that may hold various identities as consistent with IFS approach, there was a phenomenal training that was recorded by a few trans and nonbinary IFS experts on whether gender is a part, and how to navigate that when working with folks to make sure you're affirming them: Internal Family Systems and Trans Communities (<https://shifting-center.teachable.com/p/internal-family-systems-and-trans-communities>)

October 24, 2021

Comment

Thanks [REDACTED] I look forward to viewing that!

January 16, 2022

We presented on the topic of people who identify as transgender and "plural" at this summer's American Psychological Association conference. There is a robust community developing of people who identify as "plural" and there are now "plural positivity" conferences. See [pluralevents.org](http://pluralevents.org) (<http://pluralevents.org>) for more information. Some individuals have plural make-up without any trauma. (endogenic vs traumogenic)

October 27, 2021

Comment

Thanks [REDACTED] - I am excited to hear about your research and upcoming publication! I'm interested in how we understand the various experiences of plurality - and how that comes to be. Can you share some more about your thoughts about people having plural make-up without trauma?

January 16, 2022

*please* Christine N. McGinn [REDACTED]  
Hi.

I have operated on three DID patients in the past. 2 of the three were self diagnosed with a stamp of a therapist and one was more [REDACTED]

[REDACTED]

serious/obvious. 2 were vulvovaginoplasty and one was mastectomy (more serious case).

All three did ok out to the six month mark. I required an extra letter from a did specialist in all cases. I did a lot of extra hand holding on all three cases.

January 1, 2022



[REDACTED]  
We have finished our interview study on 15 trans and "plural" individuals (what may have been called DID or multiple in the past) and are submitting it for publication. There was a general consensus that mental health and medical providers need more training on this topic so they can provide affirming care.

January 5, 2022

Comment

[REDACTED]  
Really interested in your findings. Would love to read your report when it is available!

January 14, 2022

[REDACTED]  
As soon as the interview study is published, I will try to let people know where to find it.

February 9, 2022

[REDACTED]  
I'd like to see the results of [REDACTED] interview study as well. And I imagine there aren't many therapists experienced with both DID and gender diversity issues. I've only seen one client who clearly had both, but I expect it's likely more common than we realize.


January 26, 2022



Comment

[REDACTED]  
I am a post-op trans woman - college educated and in sciences and research... according to TRANSPulse the incidence of cPTSD in trans persons is at 61.8%. I did not know. I am a product of CAMH and conversion therapy as practiced there, by [REDACTED] et al. I can personally attest that I at the time believed the theory behind the treatment that I am an individual suffering from pathology characterized by the belief that I was a girl despite the fact that I had a penis. Eventually I went back to university and studied psychology for myself where I discovered that I was not suffering from any actual pathology related to being trans. I have also suffered the LGBTQ purge in the Canadian Military and my current diagnoses stand at cPTSD, ADHD, anxiety, and depression. I would add there that I believe most of the physicians on this forum are cisgender and, in my opinion, often do not demonstrate complete sensitivity to the needs of transgender patients. This is not intended as a put down. Someone who is "not", simply cannot do the following. My professor in psyche

c) WPATH members discuss a patient with undiagnosed mood disorders who threatened medical staff

**DISCUSSION**

 **Communication about Dangerous Patients**  
By **Thomas Satterwhite** [REDACTED]  
[REDACTED]  
Founder/CEO

 1,137 Discussion Views  
 7 Responses

I had a patient who became dangerous/threatening to our care team post-op, which ultimately ended in a restraining order. This patient had undiagnosed mood disorders that did not surface until post-op, after which, she travelled around the country to find other surgeons to provide care.

As a surgeon, I never want to violate a patient's rights or impede care in any way, but I also want to make my fellow surgeons aware of this past history.

When dealing with patients who have extreme negative interactions with a care team, whether it be due to a personality disorder, trauma, or any other factor, what can we do to communicate between physicians to let other surgeons know that there can be a potentially dangerous patient, in an appropriate medicolegal fashion?

[REDACTED]

This is a poignant and important dilemma. One way of navigating this may be to ask (and look at the literature on) what you would do if it was a patient who required other types of critical healthcare. For instance a patient that required ongoing heart-related healthcare but had been violent or otherwise difficult with providers. Another consideration is whether applicable privacy law in your jurisdiction permits you to reach out to colleagues in this way.

Not sure this qualifies, but I have had two "fall in love" w/me (more likely obsessions) and it was v hard to untangle things between us. I ended up consulting a psychiatrist for advice on how to terminate the relationship. They wanted a S/M contract and I had to consult an SM person and learned the language about "contracts" per that milieu. In both cases, I was concerned about personal safety for a bit. There were no previous indicators available in both cases. I guess I could use advice on how best to detach when the relationship is no longer beneficial for either party.

Comment

Dan H. Karasic  
In the US, I don't think you can reveal protected health information without consent of the patient, unless there is a specific threat to another person (e.g., with Tarasoff warnings). However, if the patient is seeking a revision or other follow up care, the new surgeon should require a release of information form to be signed to communicate with the original surgeon, and at that point the surgeons can discuss the threatening behavior.

Comment

Indeed, only possible with a signed information form!!

If we set aside whatever state laws may be applicable, my understanding is that HIPAA permits disclosure of PHI between providers for treatment and coordination of care (link below in reference to mental health information specifically). I believe one course of action here would be to contact this patient's mental health letter writers, with whom you already have a coordination of care relationship. They should be notified that their patient has displayed symptoms of impaired mental health, particularly given that (1) these symptoms are relevant to surgical readiness and (2) they are the clinicians most likely to be asked to renew m...

Read more

Comment

You are correct. The 2 provider evaluations you received is the informed consent and allows you to (unless the patient has provided you in writing a specific retraction of coordination of care) contact those 2 providers.

It's no different than a specialist getting a referral from a PCP and sending their note after consultation back to the PCP.

Hopefully, a surgeon who assumed care of such a pt would reach out for previous records at which time all of this would be identified?

Comment



d) WPATH members discuss initiating hormone therapy for a patient with trauma

**DISCUSSION**

**Initiating Hormone therapy in the midst of trauma focused therapy (TFT)**

662 Discussion Views  
4 Responses

I'm struggling with a patient dx with PTSD, MDD with well documented, and observed dissociations. Moreover, a recent personality test suggested schizoid typical traits. They were referred to me to discuss HRT and eager to start. Psychiatry is recommending holding off, the patient is becoming more and more frustrated with me not moving forward with HRT. They are looking to me as a "trans expert" who is not helping them. My practice is based fully on the informed consent model however this case has me perplexed; struggling internally as to what is the right thing to do.....

Submit

Dan H. Karasic

I'm missing why you are perplexed. Does the mental illness impair ability to give informed consent? Is there not persistent gender dysphoria? What is the nature of the dissociations, and do you believe it impairs ability to give informed consent? Why is the psychiatrist recommending holding off? The mere presence of psychiatric illness should not block a person's ability to start hormones if they have persistent gender dysphoria, capacity to consent, and the benefits of starting hormones outweigh the risks. Your client is under the care of a therapist and a psychiatrist (and presumably being treated for PTSD and depression), who can help manage emergent mental health symptoms. So why the internal struggle as to "the right thing to do"?

Comment

[REDACTED]  
Understood,

But I don't see how HT would interfere negatively with the symptoms your patient is experiencing, nor with trauma focused therapy. In fact, withholding HT can make the patient experience more distress and thus intensified symptoms. I've had patients/clients with diagnosed DID, MDD, bipolar, schizophrenia, etc., who do just fine on HT. Think of it this way - would you deny a cisgender patient with the same psychiatric dx hormone therapy if they were hypogonadic? This is harm reduction and so doing nothing is not a "neutral option."

Comment

[REDACTED]  
I agree with other comments. Start slow, be careful. With severe PTSD with dissociations, if the client isn't making progress with current psych, switch. They might have better ideas on calming the glutamate receptor such as use of NAC, Lithium, memantine to slow down the triggering and dissociation. It is good this client has someone who cares, which is the most important thing they need.

Comment

[REDACTED]  
I agree with previous comments, and I strongly recommend reading this article on the matter: Kinnon R. MacKinnon, Daniel Grace, Stella L. Ng, Suzanne R. Sicchia & Lori E. Ross (2020): "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, DOI: 10.1080/00207411.2019.1711328 (Abstract (<https://www.tandfonline.com/doi/abs/10.1080/00207411.2019.1711328>))



e) A WPATH member questions the surgical readiness of patients displaying serious mental illness

The screenshot shows a forum post with the following content:

**DISCUSSION**

**Serious Mental Illness and Readiness for Medical/Surgical Transition**

4,670 Discussion Views  
5 Responses

I have several trans clients with serious mental illness. For example, bipolar disorder and autism or schizoaffective disorder. Even though these clients have a well-established trans gender identity, their likely stability post initiation of HRT or surgery is difficult to predict. What criteria do other people use to determine whether or not they can write a letter supporting surgical transition for this population? In particular, given the extensive recovery period and postnatal care required for vaginoplasty, have other clinicians found that their clients with serious mental illness can follow post-surgical dilation protocols?

Submit

Thank you for posting this [REDACTED]. I have a number of cases of folks with significant mental health issues (with various markers of "stability") including Autism Spectrum, PTSD/C-PTSD, Psychosis. I think part of our role is in treatment planning toward mental health sx stability pre and post medical interventions including surgery. In my mind this necessitates interdisciplinary, collaborative care and planning.

To be frank, I have a few who are (or will likely be) in a sort of holding pattern because of the lack of mental health and other support resources that I am recommending.

Does anyone know of literature on medical AND psychological outcomes for these/similar issues?

Hello,

It depends on many factors that equally affect those without any psychiatric concerns - do they have a support system with actual humans to help them on a daily basis, do they have a safe place to recover, and do they understand instructions such as dilate, wash, monitor - or do they have one or two persons who can help? Also - autism is neurodivergence on a spectrum with variability in function but not classified as "serious mental illness." In addition, as gender affirmative practitioners, we always consider harm reduction as our primary lens - in other words, what will happen to these patients if they do NOT undergo their affirmative treatment, which is also a medical necessity?

In my practice, I have found that those with diagnosed psychiatric concerns, e.g., schizophrenia controlled by medication, usually have a prior support system of sorts and can get help. But I have also intervened on behalf of people who have been diagnosed with major depressive disorder, cPTSD, homeless and got at least an orchiectomy - which made a huge difference in their lives and put them on the road to emotional recovery and enabled them to seek assistance (and yes, they were successful). To me, the letter is an assessment of mental capacity to provide informed consent; if such capacity clearly does not exist, the patient needs to be informed and a new appointment for changes in psychiatric meds or at least one discussion with their treating psychiatrist need to happen. I am personally not invested in the "well controlled" criterion phrase unless absolutely necessary, and I believe it's disappearing in the SOC v 8 version. Meanwhile, in the last 15 years I had to regrettably decline writing only one letter, mainly b/c the person evaluated was in active psychosis and hallucinated during the assessment session. Other than that - nothing - everyone got their assessment letter, insurance approval, and are living [presumably] happily ever after.

Comment

Correct me if I'm wrong, but my impression is that the SOC7 recommend a letter stipulates: "While the SOC allow for an individualized approach to best meet a patient's health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional." The letter of support is primarily to establish the primary/durable indication for surgery: gender dysphoria. And while this likely qualifies as an individualized approach, I'm concerned that denying necessary surgical care (even for the severely mentally ill) encroaches strongly on a patient's autonomy—presuming the patient in question has capacity to make their own medical decisions.

If you've already established persistent gender dysphoria to your own threshold of assessment, then the role of mental health here may simply be one of "optimization" rather than clearance. Any medical doctor would do the same prior to necessary operations by a surgeon as well. It would be great if every patient could be perfectly cleared prior to every surgical intervention, but at the end of the day it is a risk/benefit decision between you, the patient, the surgeon, and any other resources/family you can recruit to help promote the best outcome for the person(s) in question. If a patient can't follow a



dilation schedule, they may lose depth, but as long as they're capable of making that decision of sound mind while fully informed of the risks, then that may be all you can do. Please keep in mind that any surgeon should also be assessing for risks and ability for a person to recover optimally since they are more intimately familiar with post-operative complications, so you're not alone in your fear of complicated outcomes.

Comment

It is my understanding that for top surgery (roughly) that medical and mental health issues need to be "reasonably well-controlled" and for genital surgery, the issues need to be "well-controlled" according to SOC 7. However, there is not a clear line on what well-controlled versus reasonably well-controlled are. It's a clinical judgment from the best I can tell, and I use consultations with my WPATH Mentors (they are so awesome and have so many years of experience to bounce things off of) to determine this if I have concerns. I think an interdisciplinary team approach to helping someone get what they need. Also, I like to adopt the "and" framework rather than the "or" framework for this. Someone can have schizophrenia and be ready for surgery...it is just a matter of what you see concerns are, communicating those concerns, and working in a patient-centered way with a team (ideally) to help them get to close to the goals as possible for surgery readiness. I also believe that collaboration with the surgeon(s) is ideal because their staff can help support with aftercare realities and a plan for pre and post-op care. I also am reminded that it has been pointed out to me that withholding care (letters of referral, etc.) is more problematic when compared to the provider's feelings about the potential for stability after surgery and/or difficulty with following through with aftercare instructions. things like exploring minimal depth vaginoplasty are also an option. I say all of this in the most client-centered and supportive way to help patients get what they need for care. Thank you!

Comment

My feeling is that, in general, mental illness is not a reason to withhold needed medical care from clients. Doing so just increases the day-to-day level of distress these clients are called upon to manage, in the form of gender dysphoria. In contrast, receiving gender-affirming care can often significantly stabilize client's mental health.



My assumption is that you're asking this question because you're taking seriously your responsibility to care for and guide your clients. Unfortunately, though, I think the broader context in which this question even exists is one in which we, as mental health professionals, have been put inappropriately into gatekeeper roles. I'm not aware of any other medical procedure that requires the approval of a therapist. I think requiring this for trans clients is another way that our healthcare system positions gender-affirming care as "optional" or only for those who can prove they deserve it.

Even if your clients might struggle with some of the needs and challenges that come with surgeries, for example, I believe that they will likely be better off in the long run. More importantly, I also believe that they have the right to access that care if they choose.

3) SURGICAL OR HEALTHCARE COMPLICATIONS

a) A WPATH member reports their concerns regarding their patient's urethral ejaculate



DISCUSSION

 **Urethral ejaculate**  


Gender Affirming Surgery (474 members)


1,272 Discussion Views  
6 Responses

Hi everyone.  
I have a transgender patient who underwent full depth vaginoplasty a year ago (penile inversion technique). She notices an ejaculate with orgasm through her urethra that "smells like semen" and is bothersome. Although I am a gynecologist I assume this is residual prostatic secretions. Is there a solution? I have asked her surgeon as well if he has heard of this. Thanks!

 **Daniel D. Dugi** 

All the anatomic structures that produce semen (prostate, seminal vesicles) are still present after vaginoplasty. Typically people experience the greatest change in their fluid production when they start estrogen and block testosterone. After vaginoplasty, the muscles to expel the fluid are gone so the fluid won't come out as quickly, but they will likely have the same volume of fluid.

To my knowledge, there is no surgeon in the world that removes prostate and seminal vesicles at time of vaginoplasty—too invasive and risk of untreatable urinary incontinence. I don't think there is remedy.

 Hi all,

As a woman of trans experience who had bottom surgery 40 years



ago, I say enjoy the ride. In my experience, it's the ultimate physical sign of orgasm...what's not to like?

Comment

Hello

With classic vaginoplasty, the prostate and the seminal vesicle remain in the body. Therefore, it is quite possible that during orgasm, seminal secretion, of course without sperm (because the testicles are removed), runs out of the urethra.

Comment

I suggest you consult your surgeon!

Patient may need revision Bbecause muscle of ejaculation did not cut it off.

Maybe testes still, and when patient is feeling they want to have sexual activity her canal will narrow, I guess!

Please return to surgeon and have physical examination.

Comment

It's true that the secretion from the prostate is still functioning after the surgery and some cases the transex hormone and the removal of testicles can lower the function of the prostate but in some cases have to wait for that result and some cases will bother the sexual activities. For the cases that have much water I have to inform the patients and accept it or use the cleaning gel to reduce the smell. Wait for other surgeons discussion.

Comment

Hello

Yes it is prostatic fluid. the only way to eliminate it would be by a prostatic resection with all the posible consequences that it comes with it. It is important to advice patients about this before surgery, so they know it could happen

b) A WPATH member discusses the development of hepatic adenomas on a client taking testosterone/estrogen

**Hepatic adenomas and testosterone/estrogen**

[REDACTED]

Hi colleagues/friends: Wondering if anybody else has had to navigate the development of hepatic adenomas in a young person treated with testosterone and/or oral contraceptives. Without getting into too many patient-specific details, our team has a 16 y/o patient who was on norethindrone acetate for several years for menstrual suppression and who has been on testosterone for slightly over one year. Pt found to have two liver masses (hepatic adenomas) - 11x11cm and 7x7 cm- and the oncologist and surgeon both have indicated that the likely offending agent(s) are the hormones and have recommended the treatment ceases at this time to allow for regression of the masses. We are prepared to support the patient in any way we can (e.g. IUD, top surgery when medically stable, etc). however we are wondering if others have experience with this situation.

December 1, 2021

Submit

[REDACTED]

I have one transition friend/colleague who, after about 8-10 years of T, developed hepatocarcinomas. To the best of my knowledge, it was linked to his hormonal treatment. He was in his midlife. Unfortunately I don't have much more details since it was so advanced that he opted for palliative care and died a couple months after.

February 24, 2022

c) A WPATH member reports their young patient is experiencing vaginal pain on testosterone

**Vaginal pain in transmasculine patients on testosterone**

[REDACTED]

Hello, does anyone have insight on vaginal estrogens for vaginal/pelvic pain/spotting in patients on testosterone? I have a young patient on testosterone x 3 years who saw me after empiric PID treatment in the ER. None of his symptoms resolved, and all of his testing and imaging is normal. He has atrophy with the persistent yellow discharge we often see as a result. Amenorrhea for the past 3 years and using Premarin cream 0.625. The Premarin appears to have stopped working. Has anyone had luck with estrace tablets vs cream? Do you ever supplement with vaginal moisturizers or hyaluronic acid suppositories? Thank you very much.

March 24, 2022

Submit

[REDACTED]

If you have a compounding pharmacy near by, compounded estriol cream works really well. I order 4 mg/gram and have them insert 1/4 gram daily for a week then 1-2 times a week thereafter. In my town, it costs \$45 for 30 grams that lasts several months.

April 2, 2022

Comment

[REDACTED]

Thank you very much for your suggestion!

April 6, 2022

[REDACTED]

I have found with a few patients, that topical/vaginal estrogens can help with some of the atrophic changes that may occur with testosterone. Some patients have developed pelvic floor dysfunction and even pain with orgasm and I have found that pelvic physiotherapy can also be helpful for that condition.

April 3, 2022



I developed vulval lichen planus and lichen sclerosis, 20 years after commencing testosterone treatment, and 17 years after hysterectomy. I had splits in the skin which bled, and were excruciating. I was initially told it was a consequence of using biological washing liquid, but a change made no difference. Eventually I took myself to the GUM clinic, the consultant sought advice from [REDACTED] who very kindly responded, suggesting an oestrogen (Ovestin 1 mg) cream. As a migraine sufferer, it was essential to minimise the treatment regime, as there is a raised risk of stroke. I used 5mg daily initially, until the conditions settled, then gradually reduced to a monthly maintenance treatment which I continued for a further 12 months.

For the next 10 years or so, the condition used to reappear every few months. I would use the same treatment but only during the initial flare-up. It would take only a day or 2 to control the condition. So I have often silently thanked [REDACTED]

Gradually the conditions resolved entirely (I hope) with no recurrence for the last 20 years. This seemed to coincide with my change from Sustanon 100 injections to 16.2mg/g x Testogel Pump. I then struggled with menopausal symptoms including extremely uncomfortable and visible hot flushes. These were resolved by increasing my daily dose from 40, 55mg to 81mg.

To this day, if I forget to use the gel, I will have hot flushes by the evening.

I wish we could do the same for the oral versions of lichen planus and sclerosis which have plagued me throughout my adult life.

I often silently thank [REDACTED] for my sex life.

April 3, 2022

Comment

I used to have bleeding after penetrative sex. It would hurt to have an orgasm. My gynecologist initially prescribed estradiol cream. I was to put it on at night. The thing about the cream is that it gave me that "gush" of starting your cycle every morning. I have since switched to the estradiol ring. I change it every 3 months. My uterus atrophied also.

April 27, 2022

Comment

Unrelated, but for those with pain with orgasm only, I have two Trans men who have had success with taking lowest dose immediate release hyoscyamine 30-60 minutes prior to.

I have only 2 Trans male patients who preferred the compounded DHEA 10mg vaginal suppositories for atrophy, both because it has the cost of compounding and ideally it is done every day until goals of treatment are achieved and then most can go down to 3 times weekly.

Mostly I end up using DHEA for cis-females who have had breast cancer. The oncologists in my area are strict on not even vaginal estradiol after ER/PR positive breast cancer. It works well but, again they do have to use more than once weekly on going.

May 1, 2022

d) WPATH members discuss erection pain in a patient on estrogen

### Pain with erection after starting estrogen/HRT

[REDACTED]

Question from one of our endocrinologists: "Just wondering if you have any insight as to why some transwomen may experience significant pain with erections post hormone therapy. I do think there are some tissue changes although would expect that to be more specifically related to the testes and take a few years to develop. I just spoke with someone who is only been on hormone therapy for 10 months but has had already at least 4 to 5 months of pain with any erections. She is planning on vaginoplasty but is slightly concerned that this may persist post surgery. I do not think that would be the case but have you heard this from any of the folks you have seen before or after surgery?"

•

January 19, 2022

[REDACTED]

Responding first as a post-op trans woman myself. I certainly had pain with erections when I was taking estradiol before my surgery.

Erections were pretty uncommon during this period, and I tended to try to avoid having them because of this...even when they were not painful, they were physically uncomfortable and not pleasurable (not because of dysphoria, the issue was physical sensation). Since vaginoplasty (I'm four years out at this point) I've had no problem at all. Arousal is positive and without pain.

Speaking as a clinician, a portion of my trans feminine clients on HRT describe similar discomfort and/or pain. But no one I've ever talked to who is post-op has ever described this pain continuing.

My guess (and it's just a guess, I'm not a medical person) would be that the pain is related to erectile tissue in penis and that the removal

[REDACTED]

of that tissue during vaginoplasty addresses the problem.

January 23, 2022



[REDACTED]

I must say that our Transfeminine patients have not offered this complaint. I do have patient on estradiol who do desire erectile function. We try to balance or titrate Testosterone levels by attenuating Spironolactone or Estradiol to arrive a state of some preserved erectile function while maintaining estrogen effects as well. I have been treating transgendered patients since 1988 and I do not think any of my patients has offered this complaint. I will ask in the future.

February 16, 2022

Comment

[REDACTED]

In fact this is not an uncommon issue in my cohort of trans feminine patients. Colleagues have postulated it may be due to tissue atrophy. I and colleagues have found that the application of a small amount of 1% testosterone cream to the area seems to help quite a bit. Of course you do have to warn the patient that there will be some systemic absorption, so start with a very small amount and titrate against clinical effect and unwanted androgenic effects.

February 16, 2022

Comment

[REDACTED]

In my patients I see pain related to 2 different things. One is the tissue on the penis is thinner. So if they use their penis they and their partners need to try different ways to touch. The other patients that have pain it is usually related to not having erections for a while and then having an erection. The penis is not having those 5-6 spontaneous erections while they sleep. They will then go to have an erection and that tissue usually causes pain that my patients refer to as feeling like broken glass. Usually after having several erections in a row it gets better. I just warn them about these possibilities.

February 17, 2022

Comment

[REDACTED]

I have seen many hundreds of trans women and confess, similar to [REDACTED]. I have not encountered this as a complaint (other than a patient with Peyronie's disease or a penile fracture from trauma).

February 17, 2022

[REDACTED]

The transgender people under my surveillance do not complain about this matter. However, I confess that I never asked them about it. It is in my personal protocol from now.

February 22, 2022

Comment

[REDACTED]

I do not see this frequently, but definitely do see it. My patients often request topical testosterone, but as mentioned by [REDACTED], I am reluctant to do so because of systemic absorption. What I don't know is if the cause of the pain is from decreased blood flow leading to atrophy and scarring (akin to Peyronie's Disease) which may be managed by maintenance of blood flow from either more frequent erections or use of a PDE5 inhibitors, or from a direct hormonal issue which could be managed by topical testosterone. What confuses me is many of these transfemale patients still maintain detectable testosterone levels, while my hypogonadal cis-male patients do not complain of this.

February 23, 2022

Comment

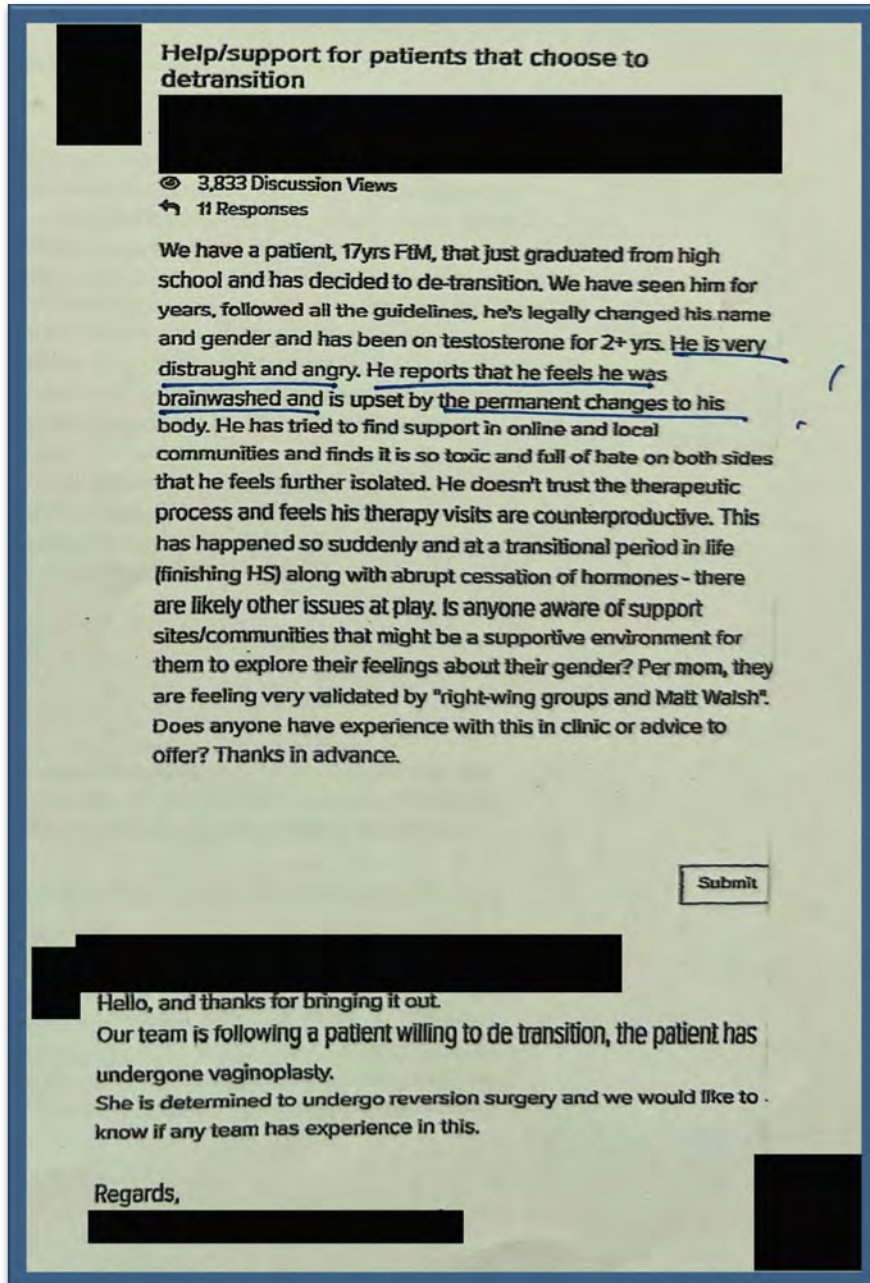
[REDACTED]

Have seen this a few times as I regularly ask about sexual health at follow up, I agree about the thoughts below about the atrophy and adjusting touch/sex with partners. Some address this with causing daily erections (I liken this to dilating for post vaginoplasty) and have tried testosterone 1% once with some success.

February 23, 2022

4) DETRANSITION CONCERNS

a) A WPATH member reports a patient who reports feeling “brainwashed” into transition





I have a patient I am currently seeing in psychotherapy who is also in high school and, medically at least, has opted to pursue a similar path. However, throughout discussion on this change in course with me and with his parents (also AFAB), he is framing it quite differently. Instead of even using the term "detransition," he is simply describing this as a turn in his gender journey. He does not regret the course he has taken so far, and acknowledges that he was the driver in getting him to this point. He also has had a very supportive environment (home, school, friends, therapy) that has allowed him to appreciate his ability to have agency in his journey, but simply says that, for now at least, he needs to take a breath, pause the T, and see how that feels to him (e.g., will it feel gender-congruent).  
 I don't have any suggestions for any group, as this young person has found what he needs in his support network and has not expressed a need for any additional support group. I would, however, be very interested in any suggestions others may have for your person.

[REDACTED]

Comment

[REDACTED]

Maybe this young person needs to engage in anti-trans platforms as a place where she (pronoun?) can connect with her anger and feel less alone. The isolation you describe is pretty typical I think, which is why I am considering starting a support group (if there are enough people interested in joining). I worked with a 16 year old who detransitioned after being on T for more that 2 years and having top surgery. She was very angry and actively engaged in anti-trans online groups. In her case, as well as with the 20 year old I am currently working with, they believe their issue was really body dysmorphia rather than gender dysphoria, and both had presented as being very appropriate for hormones and surgery.

I don't know what to recommend for your patient, especially since it sounds like she believes therapy is counterproductive. If I end up starting a support group, however, I would be happy to talk with you about whether she might benefit from joining.

Thanks,

[REDACTED]

Comment

[REDACTED]


Hi there, I am not a medical professional - I'm just a queer therapist who specializes in working with queer people, including those who navigate the transition process and gender affirming procedures.

I want to offer this portion of my response as a disclaimer: While I've supported people who've detransitioned or just experience fluidity in their gender over time, I've never witnessed someone claiming to be brainwashed. In my experience, these stories have come from people who have an active agenda against the rights of trans people and a truly insignificant number of people who've detransitioned and believe that their singular experience is part of a greater conspiracy to "turn the kids gay/trans". I think in this case it's also important to critically


consider what goes in to truly "brainwashing" someone. I'm sure you'd agree - that it's unlikely an entire network of mental and health care professionals over the span of this youth's adolescence have created a system sophisticated enough to collaborate in brainwashing a child in to transitioning. The barriers for a youth transitioning are so hard to navigate as it is, especially in a republican state like Utah where you practice.

I'm surprised to hear that this person has had difficulty finding support for detransitioners, as there's a growing number of "non-partisan" advocacy groups worldwide specifically offering support for detransitioners. They are so meticulous about how they present themselves and the language they choose, that it would be hard to identify them as "full of hate" (see the Society for Evidence-based Gender Medicine, the Gender Exploratory Therapy Association, and the International Association of Therapists for Desisters and Detransitioners). In fact, they would be ecstatic to offer a "brainwashed detransitioner" support and in turn appropriate their story for their own gain. I feel uncomfortable mentioning these organizations since I don't endorse any of them, but maybe this is the avenue this family is looking for. The latter two associations I listed have membership databases of therapists who support detransitioners. But further to this, any adequate mental health professional, queer or not, should be able to support someone detransitioning if they simply practice from a person-centered perspective.

So I guess instead of advice, I'm more so challenging the idea that those who believe they've been brainwashed into transitioning are actually lacking support, because there's a highly publicized movement of anti-trans orgs (and right wing politicians) who would gladly support this person. I fear that, based on their admiration of Matt Walsh, they might simply be making claims that support their narrative. Mental health professionals are legally bound to ethical codes that require them to provide non-coercive support services (however, I know there are many different interpretations especially in places that don't explicitly ban conversion therapy etc). But regardless, there is no lack of professionals who'd be willing to support this person as best they can.

 Comment

[REDACTED]  
Hello - I am [REDACTED] and also personally connected with many detransitioners and detransition communities online. You could send along my team's social media accounts where we are sharing personal narratives of detransition from our study [REDACTED]. You could also email me and I will share a link to a positive/trans-inclusive detrans/retrans discord server which offers support to individuals of all ages (most members are in the late teens to 20s). Unfortunately there are very few formal support resources for this population. [REDACTED]

 Comment

[REDACTED]  
I do not have direct experience with a rejection of this particular process, but do have experience with such events in psychotherapy. I have followed people's lead into a rejection of family, or family's belief system, or even indoctrination, and it seems the person is clearly, and firmly, convicted of the rightness of their course. Then a reversal occurs. Sometimes the family has seemed supportive of the individual's fight for self-representation and self-determination. In my



experience both dimensions were not as they appeared to me. The person is not as firmly committed to self direction, and the encounter with the likely consequences in family or family group. And, the family was not as sincere or wholehearted in commitment to the individual's declaration of self. I have, at times, been seen as the instigator of the individual's decisions—even up to a renunciation of family or family values and beliefs. Or, if not, as colluder or collaborator in such a reaction. It is an unpleasant experience. I know that I do not take leadership in these situations, I follow my patient's direction. Still, I know, that I have a strong effect of acknowledging and supporting autonomy and the human right to self-determination. If the individual's conflict, and the family's have not been acknowledged and worked through, then it is easier to default to the explanation, espoused by some in the world outside the family, that the person was influenced, misled, even guided into behaviors that comply with practitioners' supposed ideology. That this, of course, happens in life, makes it harder to refute. In any case, refutation has little effect because the person, and/or family, are using practitioners as authorities to rebel against and claim have manipulated and harmed them. Beyond offering that interpretation of what is happening, at least to the individual involved, there is little I know to do [REDACTED]

Comment

[REDACTED]

This reads to me as a pt who feels they have lost agency around their transition, and it's likely that therapy is the most appropriate place for them to explore this (as for support communities, I don't personally have referrals). I want to start with the fact that I don't have experience with this exact scenario and I am coming from a MH perspective, but analogously in therapy with depressed pts whose symptoms improve in treatment and suddenly doubt they ever had depression to begin with, thus wanting to abandon the very treatment that provided this relief. My approach with these pts tends to be best received by taking them at their word on their experience — assuring them that I do not doubt them personally AND will provide them with appropriate care termination pathways. Following that with information about what clinicians know from research and clinical experience: that this experience is not rare, and a portion of depressed pts (de/re-transitioners) followed over time do end up relapsing (returning to transitioning, re-experiencing dysphoria in this analogy), and frequently cite symptom relief and a desire to be "normal"/"well" (or in the case of de/re-transitioning, various external pressures/stressors) as the ultimate reason for abruptly stopping tx, when continuation of care may have been a more appropriate choice. Clarify that the team would be remiss in their clinical duty if they didn't explore the possibility that this may occur for the current pt and provide the pt with the option to continue contact with the tx team to safely end treatment and provide the best tools possible to return to care in the future. Again, not because you are doubting the pt, but because you are doing your due diligence as a trained, knowledgeable provider. It's important to strike the balance between your expert knowledge in your domain, and their authority in their own internal experience in maintaining the therapeutic relationship. Sharing the team's experience of this change appearing suddenly opens the floor to asking them if this was equally sudden for them, or if they have felt that their tx team has been an unsafe place to discuss doubts they've had for a long time. Re-establishing an alignment of tx goals, affirming that you can support them in their decision to end tx in the healthiest way possible (should that be their ultimate decision) can prevent an adverse reaction stemming from their perceived lack of support. Exploring options for partial de-transition or healthy de-transition can

give them the space they are desperately seeking to explore what this experience means to them and helps establish their care team as the space where they can openly discuss it. It might also open them up to the reality check that political pundits are not neutral support, even if their work resonates and affirm that they are allowed to explore what about the work of those pundits does resonate, openly with their treatment team. Additionally contrasting that the treatment team is not ideologically or politically motivated, but oath-bound to provide care in the best interest of their pt based on the best research available.

Explicitly state that the tx team's goal isn't to advocate for transitioning or de/re-transitioning, but to help the pt figure out the best path for themselves and support them in that, and if the pt feels they haven't been heard in some way that the team wants to give them space to tell them how and why. If the pt had experiences with the team where they felt their concerns about transition or thoughts of de/re-transition were not taken seriously in the past, it is important to affirm that the team will put in effort to rectify that. If the trust is completely gone, maybe the team can offer a referral to an alternate therapist or clinic? Hopefully this will give the pt room to explore their concerns, and help the team determine the appropriate course of tx. Should this discussion result in de/re-transition and termination of tx, it would be important for the team to provide resources for the possibility of returning to transition, again because it is developmentally and clinically indicated, not because you expect this specific person to do something they have clearly expressed a desire that they do not want to do. It is important that this is addressed as an entire team, especially with the MH provider[s]. I hope this is a helpful conceptualization. I'm unsure if others might be able to provide more evidence-based approaches or referrals in contrast to my more clinical reflection.

Comment

I have done some research around individuals wishing to detransition. I know many have found a subreddit, r/detrans to be a supportive community for them to find others with a shared experience. Unfortunately there aren't many established support groups for detransitioners, but some are finding success plugging into other local mental health support groups or other online forums like the one mentioned. I may be able to get you information about at least one specific online support group versus online forum if interested. I hope this helps.

Comment

1 Attachment



Thank you for the responses. This was just published and might be helpful/informative to others interested in this topic: PMID: 35877120 (<https://www.ncbi.nlm.nih.gov/pubmed/35877120>), Full Text (<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2794543>).



b) A WPATH member discusses another WPATH member's new study on detransitioners

**Survey Results of 100 Detransitioners**

1 Attachment

Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners  
(<https://link.springer.com/article/10.1007/s10508-021-02163-w>) –  
by WPATH Member Lisa Littman, MD, MPH

**Abstract**

The study's purpose was to describe a population of individuals who experienced gender dysphoria, chose to undergo medical and/or surgical transition and then detransitioned by discontinuing medications, having surgery to reverse the effects of transition, or both. Recruitment information with a link to an anonymous survey was shared on social media, professional listservs, and via snowball sampling. Sixty-nine percent of the 100 participants were natal female and 31.0% were natal male. Reasons for detransitioning were varied and included: experiencing discrimination (23.0%); becoming more comfortable identifying as their natal sex (60.0%); having concerns about potential medical complications from transitioning (49.0%); and coming to the view that their gender dysphoria was caused by something specific such as trauma, abuse, or a mental health condition (38.0%). Homophobia or difficulty accepting themselves as lesbian, gay, or bisexual was expressed by 23.0% as a reason for transition and subsequent detransition. The majority (55.0%) felt that they did not receive an adequate evaluation from a doctor or mental health professional before starting transition and only 24.0% of respondents informed their clinicians that they had detransitioned. There are many different reasons and experiences leading to detransition. More research is needed to understand this population, determine the prevalence of detransition as an outcome of transition, meet the medical and psychological needs of this population, and better

inform the process of evaluation and counseling prior to transition.

What has your experience been with caring for individuals who detransition or are thinking about detransitioning? How can we work to better support this population and future research in this area?

October 19, 2021

Thanks for sharing super useful

November 3, 2021

Comment

You are very welcome.

November 10, 2021

Thanks for posting this. Ten years ago, I had about 8-10 trans adult patients (all natal males) in my general practice. I learned so much through looking after them! I now have had about the same number of patients (a different and younger cohort) mostly natal females who are expressing regret and seeking help for related issues such as natal hormone treatment, fertility and childbearing exploration and so on. It's remarkable how my tiny sample looks so much like what is being described in the UK. I am in Canada.

There are rich resources in my academic city for trans youth but I struggle to find specialists who can help address the needs of this recent "detrans" group. And they are not confused, just frustrated. I am asking them to help me build a network of resources and providers using their social media connections. Once again, they are teaching me so much!

November 6, 2021

Comment

Perhaps the people at The Gender Care Consumer Advocacy Network (GCCAN), founded in late 2019, which "seeks to empower recipients of gender transition-related care to become healthy and whole" can help direct you. Their detransition members may have suggested therapists. Their website is here <https://www.gccan.org> (<https://www.gccan.org>)

November 10, 2021



My thought is that the framing around "detransition" is really important. Given the history of **pathologizing and medicalizing** transgender identity, this idea of detransition often makes it feel like a mistake has been made in some capacity. This is often used to justify further increasing barriers to accessing care, or unintentionally furthering the belief that as providers, we should gatekeep access to medical transition. I'm not saying this is what you're saying of course, it's just what I hear about often in the media and by providers who don't have significant experience working with transgender patients.

And when I think about the ways we are trying to move toward destigmatization and informed-consent models of trans health care, I think it's important to emphasize the way it is **okay for gender and interest in medical options to change over time for each individual**. I think about the many "irreversible" procedures that we allow adults to easily access in our society (cis-gender people getting plastic surgery, tattoos, etc.). And for example, the rates of surgical regret for cis-gender people getting plastic surgery (like breast augmentation) is not used as a reason why we should create more barriers for cis-gender people having (informed) access to surgery. The most recent study I saw examining post-surgical regret for cis-gender women getting breast augmentation was 47.2% expressed mild, moderate, or strong surgical regret.

And then interpersonally, the people I know who have "detransitioned" by medical standards have stopped taking hormones because they had medical complications (DVT/PE, hypertension, etc.), or hate needles, or originally took hormones to get some of the irreversible changes (eg. voice change) but never intended to stay on them long term. All of those people would be considered "detransitioners" but didn't feel like they made a mistake.

To get back to your original question on how to support patients thinking about this, I think the best we can do is support each individual and be careful with how we let this be framed by the general public. Learning new things about your gender or what you want from your medical care should be something to be celebrated, and we don't have to see it as a mistake that was made. Of course, if an individual patient feels that they made a mistake, we can support them through that as well, but hopefully we can be careful with not letting that change the way others receive care. Those are just my general thoughts!

November 6, 2021

Comment

I second the comment above. The framing of what "detransition" means is very important. I have had a number of patients plan to have permanent changes to voice, grow facial hair and then stop injections. Most topical Testosterone formulations are not covered for some. Others had breast development, laser therapy and are comfortable off Estradiol. I'm not sure how we contextualize those patients as compared to others that feel their gender identity may be more non-binary/fluid and want to stop medications or surgical treatments. Lots to understand here.



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November 10, 2021

Thanks for commenting. I believe this is probably a growing issue that will need to be dealt with by making room for a variety of voices on the subject, including those who have detransitioned. Listening to their "lived experiences" may provide us with a deeper understanding of the topic. I have appreciated watching the various videos made by the Pique Resilience Project ([https://www.youtube.com/channel/UCmGEMjyAwk6R1ITmG\\_UJLUA](https://www.youtube.com/channel/UCmGEMjyAwk6R1ITmG_UJLUA))

November 10, 2021

Definitely agree with you. What is problematic is the idea of detransitioning, as it frames being cisgender as the default, and reinforces transness as a pathology. It makes more sense to frame gender as something that can shift over time, and to figure out ways to support people making the choices they want to make in the moment, with the understanding that feelings around decisions make change over time.

November 10, 2021

I really love this...  
"Learning new things about your gender or what you want from your medical care should be something to be celebrated, and we don't have to see it as a mistake that was made. Of course, if an individual patient feels that they made a mistake, we can support them through that as well, but hopefully we can be careful with not letting that change the way others receive care."

November 17, 2021

Absolutely agree with [redacted] here. We can't say that gender is fluid then view "detransitioning" as a mistake. Instead it's a further-stigmatized part of some individuals' gender journey.

November 19, 2021

Thank you for sharing this.

I see the "detransitioning" phenomenon often among the elderly transwomen here in Indonesia. Some of them chose to detransition due to the difficulty of being rejected by their family, or environment. As they got older, it became harder for them to get money from being a sex worker, so they chose to detransition to fit into society.

I agree with the comment made by [redacted]

Informative post. [redacted]

November 10, 2021

Comment

Thanks all for bringing up this important topic, and I really agree with you that there is a danger in allowing a misleading framing like "detransition means the transition was inappropriate in the first place" to propagate. Importantly, we should note here that Littman's recruitment methods are extraordinarily skewed and the results should therefore be treated with extreme caution, and in my view, we should focus on more reliable studies for this discussion.

Like I have some serious concerns about how these kinds of 'findings' are weaponised against trans healthcare. Aside from the enormous risks in the political sphere, there's also a subtler, but I think equally serious risk at the level of individual patients – if, in seeking to prevent regret, the possibility of detransition (with or without regret) is used to raise the threshold for patient autonomy higher than "mere" informed consent, patients will simply feel unable to explore with their gender specialist any doubts or worries about interventions and/or their gender identity. Therefore, in addition to causing more trans people to be denied care they need, those patients most likely to actually end up with regrets about their transition and/or interventions will be less informed when consenting, and are more likely to undergo a treatment despite doubts. In my local trans community, I know quite a number of people who underwent serious and invasive surgery they did not want because it was made a precondition of gender recognition and, at the time, this effectively meant it was a required part of any transitional treatment pathway (Dutch News: Government apologises to transgender people forced to accept sterilisation), as well as many who regret that their transition was, for them, too "binary" because they were (or at least felt) required to express certainty to access care. Does this kind of regret matter less because avoiding it would have resulted in "more" violation of cisgenderism (not less as in the imagined would-be-cis detransitioner)?

In the end, individuals are entitled to make their own mistakes, and while medical systems and professionals can and should help them avoid mistakes, the power dynamic between a gender specialist and their patients, and between cis and trans people more generally, means that some mistakes are valued higher than others - that mistakenly not providing care to a trans person in case they regret it is assumed to be less harmful than granting a mistaken request for treatment, is just a symptom of that power dynamic. Encouraging patients to express their doubts, to make sure they're making a truly informed decision, will be impossible as long as those doubts are given weight over and above the conclusions the patient draws for themselves about the relevance of those doubts.

What I'm trying to say is that people considering transition "do" need help in working out what that transition should look like for them. what is right for them, and indeed considerations like, what options are socially safer than others, etc. But, trans communities have a long history of being disbelieved and mistreated by medical personnel, transition-related needs are often very urgent by the time the person starts to seek help, and the threat of losing access to care can motivate trans people to acquiesce to treatments we "know" we don't want, so it can definitely motivate us to hide doubts that, were they able to be properly explored, may point out ways in which the individual's needs can better be met without a particular treatment that they would later regret. But it won't get explored if that's the assumption, if the risk of regretting an action is given more weight



than the risk of regretting inaction.

So the first thing we can do to support detransitioners, retransitioners and everyone, is to make discussing doubts and complexity a normal part of the gender consult and not something that will prevent the patient from making their own informed choice. Another thing we need to do is to investigate what detransitioners want, because at present the focus of much research seems to be to use their existence to invalidate that of (other) trans people. Do they want interventions to reverse something? Are they just re-rejecting the gender binary after being shoved from one end of it to the other? If so, do they need medical/social/legal/psychological support to do so? How can we reduce the discrimination against transitioning/ed people that often precipitates a (temporary?) detransition? Most of all, how can we support detransitioners to benefit from the experience, to help them celebrate and implement the self-knowledge they've gained, and not to see themselves as "traitors" (to trans people or to their AGAB), "failures" or "mistakes"?

Your original response:

'Thanks all for bringing up this important topic, and [REDACTED] really agree with you that there is a danger in allowing a misleading framing like "detransition means the transition was inappropriate in the first place" to propagate. Importantly, we should note here that Littman's recruitment methods are extraordinarily skewed and the results should therefore be treated with extreme caution. She is not the champion of detransitioners she would like to think, and in my view, discussions centering on her work will not help anyone, and we should focus on more reliable sources.

Like [REDACTED] I have some serious concerns about how these kinds of 'findings' are weaponised against trans healthcare. Aside from the enormous risks in the political sphere, there's also a subtler, but I think equally serious risk at the level of individual patients – if, in seeking to prevent regret, the possibility of detransition (with or without regret) is used to raise the threshold for patient autonomy higher than "mere" informed consent, patients will simply feel unable to explore with their gender specialist any doubts or worries about interventions and/or their gender identity. Therefore, in addition to causing more trans people to be denied care they need, those patients most likely to actually end up with regrets about their transition and/or interventions will be less informed when consenting, and are more likely to undergo a treatment despite doubts. In my local trans community, I know quite a number of people who underwent serious and invasive surgery they did not want because it was made a precondition of gender recognition and, at the time, this effectively meant it was a required part of any transitional treatment pathway (Dutch News: Government apologises to transgender people forced to accept sterilisation), as well as many who regret that their transition was, for them, too 'binary,' because they were (or at least felt) required to express certainty to access care. Does this kind of regret matter less because avoiding it would have resulted in "more" violation of cisgenderism (not less as in the imagined would-be-cis detransitioner)?

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patients to express their doubts, to make sure they're making a truly informed decision, will be impossible as long as those doubts are given weight over and above the conclusions the patient draws for themselves about the relevance of those doubts.

What I'm trying to say is that people considering transition "do" need help in working out what that transition should look like for them, what is right for them, and indeed considerations like, what options are socially safer than others, etc. But, trans communities have a long history of being disbelieved and mistreated by medical personnel, transition-related needs are often very urgent by the time the person starts to seek help, and the threat of losing access to care can motivate trans people to acquiesce to treatments we "know" we don't want, so it can definitely motivate us to hide doubts that, were they able to be properly explored, may point out ways in which the individual's needs can better be met without a particular treatment that they would later regret. But it won't get explored if that's the assumption, if the risk of regretting an action is given more weight than the risk of regretting inaction.

So the first thing we can do to support detransitioners, retransitioners and everyone, is to make discussing doubts and complexity a normal part of the gender consult and not something that will prevent the patient from making their own informed choice. Another thing we need to do is to investigate what detransitioners want, because at present the focus of much research seems to be to use their existence to invalidate that of (other) trans people. Do they want interventions to reverse something? Are they just re-rejecting the gender binary after being shoved from one end of it to the other? If so, do they need medical/social/legal/psychological support to do so? How can we reduce the discrimination against transitioning/ed people that often precipitates a (temporary?) detransition? Most of all, how can we support detransitioners to benefit from the experience, to help them celebrate and implement the self-knowledge they've gained, and not to see themselves as "traitors" (to trans people or to their AGAB), "failures" or "mistakes"?

November 10, 2021

Comment

Thanks for sharing, following this.

November 10, 2021

Comment



Marci L. Bowers

- As you know, acknowledgment that de-transition exists to even a minor extent is considered off limits for many in our community. I do see talk of the phenomenon as distracting from the many challenges we face. I will echo other comments to say
  - All surgeries and all medical treatments have regret rates that are typically much higher than what we see for gender transition. We do not see legislatures and the media go after breast augmentation, tubal ligation or facelifts ever that I know of.
  - Medical decision making needs to remain with doctors, with patients and with parents, not the courts or legislatures.
  - Our counseling and informed consent process could use tightening.
- We all need to be better and not be afraid to listen. Criticism does not



mean blame, it means we need to do better for our patients.  
— Patients need to own and take active responsibility for medical decisions, especially those that have potentially permanent effects.

November 10, 2021

Three points to address here:

1. "Framing" of detransitioning by society is unrelated to the experience of people who made decisions in their earlier years (under 25 usually). These are young adults who made decisions to change their bodies in irreversible ways, at a time in their lives then their physical and sexual identities were in developmental flux. Many, if not most, had co-morbidities that were not fully addressed before transition was offered to them. They were rushed; they all report that feeling. And their feelings are what this discussion should be about; it has nothing to do with public "framing." "Detransition" can be called something else: regret, a change of heart, whatever. But the way it is interpreted by our community of care providers should not be weaponized to discount these real experiences by claiming they are being used as "gatekeeping" devices. The detransitioned adults I look after, if anything, are very much immersed in their own suffering, loss and grief.

2. It was stated that aesthetic plastic surgery (rhinoplasty, breast augmentation, etc.) and tattoos as "easily accessible" in society. In fact, they are only easily accessible to the privileged few who can afford them - adults or older youth with access to some degree of "luxury" funds. The hormonal and surgical interventions now so easily available to young, impulsive, mentally and cognitively unstable youth are being funded (in some countries, publicly) and advocated by registered health professionals, "framed" as "life-saving" when, to my knowledge, this claim is based on very loosely drawn conclusions from very weak data.

3. If, in fact, rates of regret for breast augmentation are as high as 47%, when chosen by compos mentis adults, that worries me deeply. I fear that rates of regret of gender transition, especially as it relates to future sexual health and fertility, in adults who make these irreversible decisions at such a young age may, in fact, be even higher.

November 11, 2021

Comment

Some excellent points made. I have seen over 600 transgender patients over the past 25+ years: more recently than distantly. Of that number, I have had perhaps 4 detransition. I say perhaps because I have a couple whose identity depends upon when you ask: for example, a natal male now in her late 40's who transitioned to female 20 years ago but has stopped therapy to detransition more than once: she (currently female) feels guilt for transitioning (religious) and loses family support when female. After many months the dysphoria is too severe, and she resumes estrogen. It is of course likely that some individuals have detransitioned and not informed me. Overall I do think the number who detransition is small and should not mean we have done something "wrong" (Agree with [redacted]). I am a little concerned that, as access to transitioning has gotten easier recently (obviously still many barriers!) that there will be greater numbers. The majority of patients I see now are below 25 years old and clearly very dysphoric. However, I am seeing some who come to

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
me with mixed feelings or misunderstanding. Hence, the importance of mental health providers!! There are a few individuals who seem to feel they should be allowed to switch back and forth merely at their request. I am not comfortable with that at this point; we need a better understanding of how to handle this type of situation.

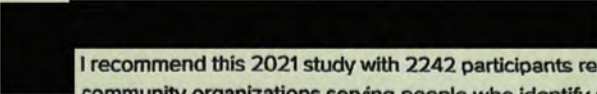
November 11, 2021



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November 11, 2021


 Comment

 I recommend this 2021 study with 2242 participants recruited from community organizations serving people who identify as Trans, gender expansive, questioning, and detransitioned. It's a bit broader than the study cited here based on the cherry-picked results of 100 curated interviewees out of 237 recruited from "detransitioner communities," which are at very high risk of being enriched with anti-trans activists. As a side note, these are the same locales where the parents interviewed for the ROGD study were recruited (not a single Trans person was interviewed for the ROGD study on Trans youth). Turban, Jack L.; Loo, Stephanie S.; Almazan, Anthony N.; Keuroghlian, AlexS. (May 2021). "Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis" (PMID:33794108, Full Text)

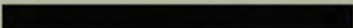
I also think that it is important to note that reliance on these inferior studies may be contributing to the suffering of Trans youth. Here's a recent report from the Trevor Project: Trevor Project: Acceptance of Transgender and Nonbinary Youth from Adults and Peers Associated with Significantly Lower Rates of Attempted Suicide

The Transgender Day of Remembrance is on November 20th, a scant 9 days from now, as people of all sorts come together across the world to remember the murdered dead and hope for a year when the numbers may someday go DOWN.

November 11, 2021


 Comment



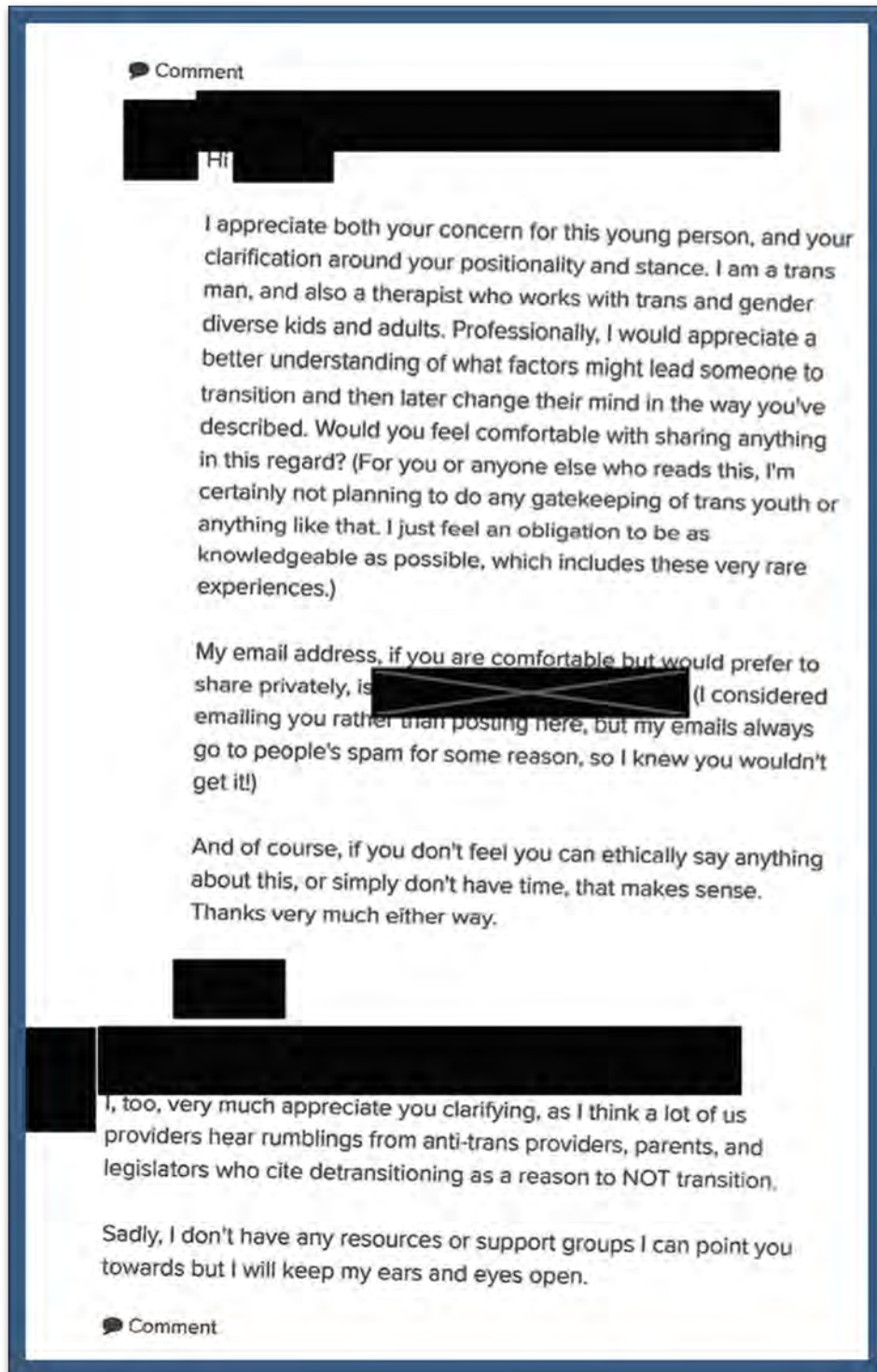
**Marci L. Bowers** 

Well said.

January 14, 2022

 Comment

c) WPATH members seek clarification on detransition



5) PUBERTY SUPPRESSION TACTICS

a) *A WPATH member questions the effects of puberty blockers on total height achievement for a 10-year-old patient*

**Blockers for Pre-Teens; Height Potential?**  
[REDACTED]

I have been reading/hearing some conflicting information about the effects of puberty blockers on total height achievement. I've recently received questions from an AFAB pre-menarche 10 y/o patient about whether blockers will "stunt" his growth if he starts them now (as his doc has approved). I understand blockers can slow the rate of growth, but for those who start them at, say, age 10, before they have hit their growth spurt, and remain on them for the total 3-4 years, what happens afterward if they opt to begin HT (testosterone), rather than resume the puberty consistent with their natal sex?

I'm curious as to how medical docs approach important issues such as stature when starting blockers, especially in earlier stages of development. Are there ways to maximize growth potential for young patients?

Thank you for your time.

February 22, 2022

[REDACTED]

It is a complex question. Blockers, by suppressing puberty, keep growth plates open longer, so younger teens have a potential to grow longer, however their growth velocity is typically at prepubertal velocity, without typical growth spurt. That is the reason we use GnRHa in children with early puberty- to give them longer time to grow.

GAHT in lower doses could promote growth (as in early pubertal stages) while in higher doses cause bone maturation and epiphyseal closure. There are other factors that impact growth potential (genetic potential, nutritional status, thyroid hormone). High BMI will also impact bone maturation and cause faster closure of growth plates and cessation of growth.

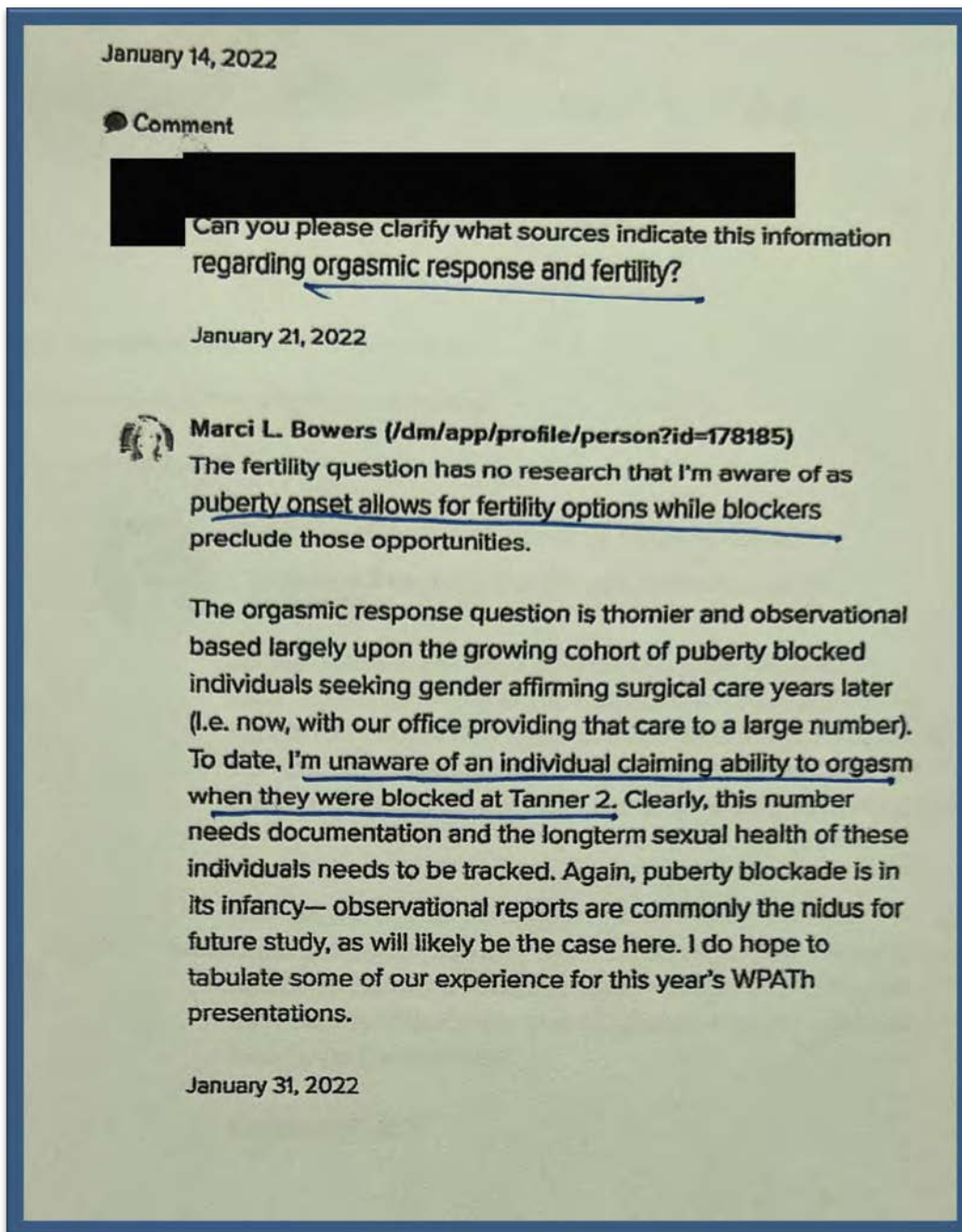
In transmasculine teens I start T at around 25-30mg bi-weekly and increase T slowly. I monitor bone age to optimize duration of growth and hopefully reach maximum height potential.

I hope this answered your question.

March 15, 2022



b) WPATH members discuss how puberty blockers preclude fertility options for trans patients



c) WPATH members share best practices for puberty suppression and hormone therapy

DISCUSSION


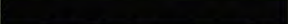
**Best Practices for Puberty Suppression**

I'm interested in starting a thread here in the forum for pediatricians providing or are interested in providing puberty suppression or gender-affirmative hormone therapy. Hopefully it will also be a good resource for allied professionals interested in learning more about how other providers are administering this care.

How do you or your clinic offer and administer puberty suppression/blockers and what resources do you utilize? What advice do you have to offer to newer clinicians or clinicians interested in offering this type of gender-affirming hormone therapy for the first time?


December 13, 2021



Submit

 Marci L. Bowers 

For AFAB persons, pubertal blockade prior to puberty is fully reversible and can offer significant likelihood of avoiding later surgeries such as top surgery.  
For AMAB persons, the issue is more complex. Same reversibility for gender exploration and same hope to avoid procedures such as Adams apple shaving, Voice drip.

January 14, 2022


 Comment

 Marci L. Bowers 

Etc. The issue is later genital surgery for AMAB persons with early blockade. We do not fully understand the onset of orgasmic response and blockers make this a major question. Fertility and more problematic surgical outcomes at adulthood are also concerns. Unless

pre-pubertal dysphoria is enormous, allowing for a small amount of puberty prior to blockers might be preferable in the long run.

January 14, 2022

 Comment

6) DOD SPENDING ON TRANS HEALTHCARE

a) *WPATH* members overview the Department of Defense's (DOD) newest report on trans healthcare finances

**US Dept. of Defense Spending on Trans Healthcare**

👁 2,564 Discussion Views  
 ↩ 15 Responses

The US Department of Defense recently released numbers detailing finances spent on transgender active duty between 2016-2021. The DOD reportedly spent \$15M between January 2016 and mid-May 2021 on transition-related medical care for 1,892 transgender service members, according to FOIA records (analyzed by Military.com) (<https://www.military.com/daily-news/2021/06/18/heres-how-much-pentagon-has-spent-so-far-treat-transgender-troops.html>).

An immediate reaction I had was that institutions such as the Coast Guard were excluded from this report (because this is technically part of the Dept. of Homeland Security) even though Coast Guard utilizes Navy resources for trans care.

Some major statistics mentioned are:

- o Service members who received gender-affirming care during this period included 726 Army soldiers, 576 Navy sailors, 449 Air Force airmen and 141 Marines.
- o \$11.5M was spent on psychotherapy, \$3.1M on 243 gender-affirming surgeries, \$340,000 hormone therapy for 637 service members, and the rest on other care.
- o While access to psychotherapy is crucial for transgender service members, some trans folks have criticized current DOD rules for imposing requirements for certain psychotherapy sessions without regard to clinical need as a part of the administrative gender-change process.
- o This amounts to about 0.045% or less than one-twentieth of a percent of the DOD's 2016 annual medical budget for health care programs of \$33.5B (which DOD is asking be increased to \$35.6B).



That means approximately \$8000 per service member. Does that sound right to you?

Submit

[REDACTED]

Their figures are seriously flawed, all skewed toward more expense, rather than less. I know this as I had access to all the financials and the methodologies as part of my analysis for the 4 Court cases against Trump administration. Far too much to cover here, but these are inaccurate and inflated cost figures.

Comment

[REDACTED]

That is very interesting. I wonder why they would do that. I thought the amounts were fairly low, considering how much phalloplasty costs and how many individuals started and completed that surgery.

[REDACTED]

1900 service members, only 600+ on HRT? What are the others doing? 243 surgeries at \$14000 per? Fox News will have a heyday with these numbers. Did they list length of service commitments required, MOS, officer vs enlisted...? Service members cannot complain about required psychological evaluation. They're there to go to war, not transition. They have to be evaluated for fitness to continue as many of us have significant psyche histories.

Comment

First, thank you for all that you do for the trans military community, it's a community that is close to my heart.

I 100% agree with you. Being in NC, I have worked with more trans military personnel since 2008 than I can count. Before Obama, I had commands send me their soldiers, sailors, air-wingers, and marines because they knew their folks needed help. All on the "down-low" or looked the other way.

Obama came into office and made it possible for military personnel (and their families) to receive trans care.....unfortunately, they were ill-equipped, untrained, backlogged, and often times just bigots.

I started seeing a surge in commands finding me and sending me their military personnel (some of my enlisted folks commanding officers paid out of their own pocket to see me....warmed my heart). They just knew their trans military folks were some of the hardest working people they had and if they just got this off their "plate" they'd be even better (cost benefit analysis I suppose).

Now this is active duty.

On the VA side, I received so many referrals from the Salisbury VA.



Again, they were backlogged and there was no one trained to help these trans vets. This went on for a few years until I got a phone call from one of their psychologist saying she needed help but that was told that the VA system would no longer be referring trans veterans to me. She asked if I would speak to her supervisor (I can't remember if he was a psychologist or a psychiatrist) regarding providing them some training. I did and he made it very clear that my services for trans vets were no longer needed nor was the training I offered. He went on to say he established a "Transgender Task Force" (sorry I thought it was a bit much, strange, and so military). This person was unfamiliar with WPATH, its protocols, the SOCs.

After a few months, the trans vets started to return stating that their hormones were d/c'd because they were still trying to coordinate or figure out how to prescribe and in the interim put into a trans group.

If they weren't paying out of pocket, I was still billing the VA but for PTSD and a doc in Winston Salem, NC worked to help me keep them on their hormones.



All this to say their numbers are absolutely wrong. If Officers, trans military members, and military vets were paying out of their own pockets, the DoD couldn't have possibly spent that amount.


Granted, it's not like I saw 100,000 people. Over the years, I know enough to feel comfortably saying, therapy is not required, hormones are cheap, and surgery, well that's a one time event. Trans care is far more affordable and far easier to manage than treating active duty, veterans, and/or their family members who have chronic illness's.


Even if that number is true (we all know it's not), it is still such a tiny tiny part of their budget. I guess my other argument is, Did they assess the numbers for treating for PTSD, hypertension, diabetes, or mental health in general?

Their skewed numbers boils down to not wanting to pay for and justifying medically neglecting those that served protecting our freedom.

 Comment

   
Surgery is definitely not a one-time event. For those members seeking genital reconstruction, it can be in 2-4 "stages." For phalloplasty, which most of my 150+ active-duty FTM patients wanted, the cost can be upwards of \$200,000 not including travel, lodging, per diem, and aftercare medical supplies and medications.

  
Sadly, many service members are still utilizing their own funds for therapy (because of confidentiality issues) and some HRT (when they are about to get out or microdosing for alleviation of Sx). I work right outside Camp Lejeune in NC - Marine base. It can be tough when they are not comfortable coming out yet and yet they need help. They cannot disclose that they are military if they wish to use the civilian clinic for HRT out of pocket. I am still thankful for the progress...when I was a Marine...it was during don't ask, don't tell.

 Comment

[REDACTED] I agree with you - I suspect that many service members are self-funding their care rather than entertaining the bureaucratic systems and the potential stigma from seeking out care. The prior presidential administration's efforts to curtail coverage weren't just focused on avoiding payment for care altogether, it was a scare tactic to:

- 1) reduce the number of trans service members;
- 2) invoke fear in those currently serving in the armed forces by creating a hostile work environment (via stigma by association); ...

[Read more](#)

[REDACTED]  
[REDACTED] For anyone working with a transgender veteran, please refer them to their closest VA LGBTQ Veteran Care Coordinator  
[REDACTED]

 Comment

[REDACTED] Hi [REDACTED] am surprised to read that the military has covered ANY gender confirmation surgery so far. I've worked with some active duty military and many veterans, but we have not been able to get any coverage for their procedures. I have tried to reach the local VA hospital surgery chairman, but never hear back. Can you please tell me where I could possibly recommend military patients go for coverage of procedures?



[REDACTED]  
[REDACTED] for Veterans reach out to their nearest LGBTQ  
Veteran Care Coordinator

[REDACTED]

For military members, they must connect with their military branches' TG Care Team Case Manager. They must follow the Defense Health Administration (DHA) protocol for getting referred to the Team (usually by their primary care provider or mental health provider). DHA requires a complex and thorough referral for the bottom surgery (TRICARE covered)...

[Read more](#)

[REDACTED]  
[REDACTED] any suggestions for care coordination for those in the military, active duty? i.e. transgender service members wanting surgery

[REDACTED]  
[REDACTED] Hi [REDACTED] For active-duty personnel wishing to access Command Approved gender transition the best approach is to encourage those individuals to speak with their Command mental health provider or primary care provider to secure a referral to their military branch medical team handling those referrals. Each branch of the military has set up the process differently. The Navy has two TG Care Teams (San Diego, CA and Portsmouth, VA). The CA Team has two case managers/care coordinators. The VA Team, last I heard, does not. The Navy teams process the referrals remotely and...

[Read more](#)

[REDACTED]

Also, because of the high need for transgender resources, if you are a clinician/therapist - you might be able to get special contract to work with transgender service-connected members if you cannot get paneled with Tricare.

Here are a couple sites that also might be helpful for trans service members:

SPARTA Pride (<https://spartapride.org/>) - certain bases will have chapters such as we do here in Camp Lejeune NC

Transgender American Veterans Association (<https://transveteran.org/>)

Comment

[REDACTED]

Feel like this information is also entirely useless out of context. How much do they spend on insulin and diabetic care? How much do they spend on mental health care for PTSD diagnosis? There are a lot of things that I'm sure they're paying money for and without any context behind these numbers or any ability to compare them people are just going to see them and make what they will of them.

Comment

[REDACTED]

I will have to go back into my records to figure out what we estimated the military costs would be back before they made the decision to cover services. There was a cost study by the Palm Center that I was asked to review before they sent it to the DoD. I did and I thought their figures were wrong and told them so. If I recall right, I thought they were estimating too high. But it could be the other way. But they probably weren't so very wrong that it really mattered. Especially because it does not matter how little is spent on transgender care: as far as the public is concerned even a dime per person is too much.

...



7) SURGICAL RISK AND PRIOR HEALTH CONDITIONS

a) *WPATH members discuss the risk for a patient that has Becker Muscular Dystrophy (BMD) to undergo transition surgery*

**Becker's MS and gender affirming care**

[REDACTED]

Good day. I am a primary care provider who provides LGBTQ+ healthcare and recently saw a new patient for gender affirming hormone therapy with the goal for future gender affirming surgery (vaginoplasty).

Patient is a 22 yo trans woman who has a history of mild form of Becker MS, (rather than Duchenne) phenotype. The patient has been followed on a regular basis by a neuromuscular provider since childhood; maintains ambulation with no symptom progression. They have an x-linked inheritance which shows there is a 1/2 or 50% risk if assigned male at birth.

I cannot find any reason why we cannot proceed with gender affirming hormone therapy. But, patient is adamant on getting a vaginoplasty in the future and would like me to guide them regarding what risks/benefits would be around anesthesia. Does anyone have any literature regarding the above pertaining to transgender patients?

I have found one recent study regarding laparoscopic gynecological surgery in cisgender woman with Beckers MS with the use of cisatracurium and inhaled sevoflurane, with a positive outcome.

I know this will be an interdisciplinary effort, but any information would greatly be appreciated. Thank you.

February 25, 2022


Submit

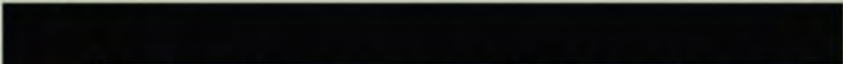
[REDACTED]

To answer your question about anesthesia and GA surgery, there is a lack of literature. I am working on publishing a case series of perioperative outcomes for over 200 GA we do at our institution. We created a speciality anesthesia team for gender-diverse youth and


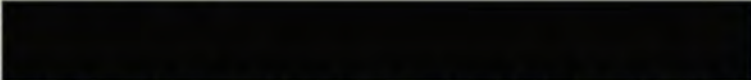
developed Enhanced Recovery after Surgery ERAS and anesthesia management guidelines for chest reconstruction, phalloplasty, metoidioplasty and vaginoplasty procedures. There are risks with transgender patients who have co-existing morbidities such as DM and may affect anesthesia and pain management. Please feel free to reach out to me to discuss more.

March 1, 2022

 Comment

  
Thank you for your response. I just may take you up on your offer! I will be in touch. Are the EAS and anesthesia management guidelines accessible to folks outside of the organization?

March 10, 2022


   
Please see our attached article (and link) the Gender Affirming Surgical Program (GASPP) in the Department of Anesthesiology, Critical Care and Pain Medicine at Boston Children's Hospital has done to advance the perioperative care for transgender youth.

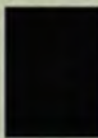
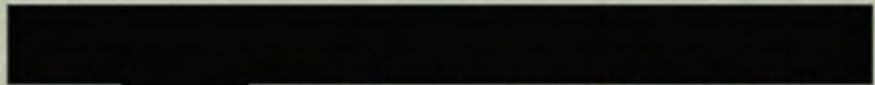
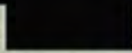
A Single Center Case Series of Gender-Affirming Surgeries and the Evolution of a Specialty Anesthesia Team  
(<https://www.mdpi.com/2077-0383/11/7/1943>)

March 31, 2022

The attached PDF is an excellent review of the risks of general anesthesia for patients with muscular dystrophies, including Becker's (PMID:19762730 (<https://www.ncbi.nlm.nih.gov/pubmed/19762730>), Full text ([https://journals.lww.com/anesthesia-analgesia/fulltext/2009/10000/malignant\\_hyperthermia\\_and\\_muscular\\_dystrophies.10.aspx](https://journals.lww.com/anesthesia-analgesia/fulltext/2009/10000/malignant_hyperthermia_and_muscular_dystrophies.10.aspx))). Of course, a detailed pre-operative pulmonary and cardiac evaluation will be essential for your patient prior to her vaginoplasty procedure.

March 1, 2022

 Comment

   
Thank  I am in the process of doing my due diligence with patient in regards to above. I have done the research and notes a few studies around anesthesia and MS. I will take a look at the review.



March 10, 2022




8) COMPLICATION RATES AND INFORMED CONSENT

*a) A WPATH member poses questions regarding standards for informed consent and the reality of complication rates*

**DISCUSSION**

 **Discussion of surgical complication rates & assessments (referral letters).**  


**Transgender Mental Health** (2151 members)

 1,895 Discussion Views


Hi all,

I have been thinking more about what it looks like to obtain fully "informed consent." I was curious to what degree, if any, other mental health providers discuss actual rates of surgical complications with clients when providing assessments for surgical care (e.g., pain or loss of sensation, need for additional surgeries, necrotic tissue, infection, hematomas, strictures, implant-related complications, etc.).

I am also curious if others think it is safe to assume that surgeons disclose actual complication rates (vs. informing clients that these complications may happen).



I realize research on some of these complications may be limited for various reasons.



Thanks in advance for your thoughts!

Best,  




b) A WPATH member explains that the traditional model of informed consent is cis-normative

DISCUSSION

 **Informed Consent Models of Care**  
Professor 


 1,268 Discussion Views  
 3 Responses



What evaluation has been done on informed consent models of care?


 




Madeline B. Deutsch (2012) Use of the Informed Consent Model in the Provision of Cross-Sex Hormone Therapy: A Survey of the Practices of Selected Clinics, *International Journal of Transgenderism*, 13:3, 140-146, DOI: 10.1080/15532739.2011.675233 (Abstract (<https://psycnet.apa.org/record/2012-12402-005>))


But I'd also look at the vast literature on the uselessness and dehumanizing nature of the assessment process - the 'traditional' model has had no real evaluation and does not appear to be grounded in much more than 'commonsense' cisnormativity.

 Comment

 3 Attachments

Hello 


Here are 2 studies I know of. I've also included references to pertinent ethics articles that may also be of interest.




- Deutsch MB. Use of the informed consent model in the provision of cross-sex hormone therapy: a survey of the practices of selected clinics. *Int J Transgenderism*. 2012 May;13(3):140-6. (Abstract (<https://psycnet.apa.org/record/2012-12402-005>))

...

[Read more](#)

 [Comment](#)

 1 Attachment



Hi 

I also recommend:

Clark, B. A., & Virani, A. (2021). This wasn't a split-second decision": An empirical ethical analysis of transgender youth capacity, rights, and authority to consent to hormone therapy. *Journal of Bioethical Inquiry*, 18(1), 151–164. (PMID:33502682 (<https://www.ncbi.nlm.nih.gov/pubmed/33502682>), Full text (<https://link.springer.com/article/10.1007/s11673-020-10086-9>))

...

[Read more](#)

 [Comment](#)

9) INSURANCE IN GENDER MEDICINE INTERVENTIONS

a) A WPATH member expresses concerns regarding data privacy in conservative areas

**ICD10 and Protecting Patients**

[REDACTED]

512 Discussion Views  
3 Responses

I have an ICD10 question. A decade ago, for privacy reasons, I would switch from a F64.9 diagnosis to a hypogonadism diagnosis as soon as it made sense, especially for those who had insurance through their workplace. It also helped improve privacy at the pharmacy pick up window. Too many people have suffered violence, and I want to protect them as much as possible. I don't feel the same pull toward privacy these days, but perhaps I am taking too much for granted. I practice in Ann Arbor, Michigan but see clients from areas of Michigan that are far more conservative.

I know I code towards hypogonadism on pharmacy claims when I see a client from Bay City or Saginaw or Mount Pleasant. I want the numbers to be evident to insurers; I don't want these clients to be invisible, yet I feel the balance rests on privacy and prevention of violence, as this is still a concern in many areas of this country. I keep the F64.9 or F64.2 in their active diagnosis list so I can pull a patient list when needed.


Submit

[REDACTED]

I have switched to hypogonadism code after gonadectomy. I know that historically some providers used this code for visits, labs and meds if someone's insurance didn't cover F64.0 or F64.9, but ethically I have not felt comfortable doing this if the person's natal gonads were intact. I realize this is not based on a guideline and would like to know what others are doing.

[REDACTED]


What happened to endocrine disorder NOS as an alternative?

 Comment

[REDACTED]

This is challenging to navigate - while the hypogonadism and endocrine disorder NOS are helpful to offer privacy and safety, justifying these codes to an insurer frequently results in an insurer pushing back for lab work justifying low testosterone or low estrogen at certain intervals (usually with an annual PA for controlled substances). For someone on long-term hormone therapy, justifying this is nearly impossible without going off of their hormones for a period of time to meet an insurer's required lab levels for coverage.

I would advise asking your patients directly about their comfort, explaining to them the logistical issues associated with obtaining medications (i.e. coding, concerns with privacy), and creating a course of action in collaboration with the patient. Presuming that a patient has coverage for gender-affirming care in their plan, I would consider keeping gender dysphoria-related ICD-10 coding (most insurers will not require bloodwork for this diagnosis) and advising requesting meds through their insurer's preferred mail order pharmacy - this negates potential conflict or safety issues with a less affirming pharmacist in their area. Another benefit of a mail-order option is that a patient can obtain a 90 day supply of their meds, also reducing potential pharmacist-patient contact.

 Comment

b) WPATH members discuss how to classify gender dysphoria using ICD for insurance benefits

**DISCUSSION**

**Gender Dysphoria - ICD 64.0 or 64.9 for Gender-Affirming Surgery Letters?**

**Transgender Mental Health** (2128 members)

6,941 Discussion Views  
16 Responses

Hello!

I am a therapist who dedicates part of my practice to writing pro bono letters. was told when I began writing psych clearance letters for gender-affirming surgeries to use ICD code 64.0 for Gender Dysphoria. However, some centers recently are asking for 64.9. What is the best code to use in general? And, has it changed?

Thank you in advance!

I work for the hospital and give letters for Gender Affirming surgeries in state of Florida. So far except for the ICD 64.0 no one has asked for 64.9. If the psychiatrist who gives a second letter of recommendation, chooses to use it, its their wish. So far I have not come across this as an issue. However, it differs from state to state. I would suggest you contact your State Board if you are really concerned about the diagnosis or the letters. Also, remember not all surgeons are well versed with the WPATH SOC, version 8.. So maybe calling and clarifying your rationale for surgery or including it in your letter might help make the process easier.

Comment

Thank you! I always used 64.0 as well, until this specific center asked for 64.9. I will write to them directly and ask why.



[REDACTED]  
Insurance isn't taking 64.0 for me.

Comment

[REDACTED]  
interesting!

[REDACTED]  
Did it used to?

[REDACTED]  
It may have to do with wording. F64.0 in the DSM is Gender dysphoria in an adult or adolescent, but in ICD-10 its title is Transsexualism and F64.9 is gender identity disorder, unspecified. If you're reading diagnostic criteria in both the DSM and ICD-10, F64.0 is the most accurate but F64.9 isn't. Inaccurate. I know in our EMR if you search the diagnosis with DSM title it only comes up as F64.9. I end up manually coding F64.0 and then modifying language to match DSM.

Comment

[REDACTED]  
"F64.0 is the most accurate but F64.9 isn't inaccurate" - that is exactly the thesis statement here! I wonder if we can list two F diagnosis to cover all bases.

[REDACTED]  
This tracks with what I have noticed as well. My EHR will list Dual role transvestism, and my staff cannot figure out how to change the wording in our system. So I have moved to using F64.9 more often for that reason.

[REDACTED]  
It sounds like you are writing for gender care services that specify they want a diagnosis. As my writing style for letters has evolved over the years, I have made an effort not to use a diagnosis when sending information to insurance companies. And so far, I haven't been contacted and asked for a diagnosis. Instead, my letters read something like "X meets the recommended World Professional Association for Transgender Health (WPATH) Standards of Care guidelines for the type of surgery he is pursuing." Then I outline all of the criteria and provide information to support that the person fits the criteria.

Comment

[REDACTED]  
interesting [REDACTED] I did not know they would be approved without the diagnosis!

[REDACTED]  
LPC-MI/ISP in Tennessee here.

I've so far (fingers crossed) never had a letter rejected (mostly BCBS, United). I've never this far used F64.0—"Transsexualism" if I'm remembering correctly—as it hasn't yet described clients I've seen seeking letters. I've been using F64.9, which in some electronic health care systems (I've called mine about this and griped about it to them) automatically defaults to "Gender Identity Disorder" but in the coding of DSM-V, I see as being "gender dysphoria in adolescents and adults." So I put that title in with the proper F64.9. So far so good.

In my letters I've been specifically identifying both the ICD-10 code for insurance purposes and...

Read more

Comment



...to gender identity disorder, dysphoria.  
Maybe they just want something with extra numbers????

Comment

Only F64.9 indicates dysphoria. For some GID surgeries especially ones that could be considered more cosmetic there has to be a diagnosis of dysphoria to get them covered by insurance. F64.0 only indicates gender identity disorder (GID) which does not imply dysphoria. Certainly if one has the dysphoria they also have the GID so I usually include both diagnoses in every letter I write as both are true and help indicate the medical necessity of the surgeries.

Comment

Correction: F64.0 is supposed to indicate both but I find that insurance seems to think the F 64.9 is dysphoria so have had trouble when using just F64.0.

Unspecified Gender Dysphoria  
302.6 (F64.9)

This category applies to presentations in which symptoms characteristic of gender dysphoria that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for gender dysphoria. The unspecified gender dysphoria category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for gender dysphoria, and includes presentations in which there is insufficient information to make a more specific diagnosis.

Comment

Hello there! I am an LMFT in CA and I just had two letters bounce back from a CA based surgery center requesting F64.9 instead of F64.0. I have written many letters for them before without issue. Also, in March my EHR, Simple Practice, changed all of the diagnostic code wording from the DSM 5 wording to the ICD 10 wording. Thankfully, I am able to edit the dx code wording in Simple Practice to align it with the less pathologizing DSM 5 wording as opposed to the ICD 10. I have reached out to both the surgery center and my EHR to inquire about the reasoning and timing of these changes.

Comment

c) WPATH members characterize a two-letter requirement for transition surgery as gatekeeping

**Writing a Letter for 17-Year-Old: Insurance Requests 2 Letters**

[REDACTED]

Psychotherapist

4,847 Discussion Views  
20 Responses

Hi there,  
I am writing a letter for a 17-year-old for gender-affirming top surgery. Their mother reported to me that the surgeon's office is requesting 2 letters at different dates to submit to the insurance. The only instructions they received were the letters need 2 different dates. Has anyone been asked to write a second letter, and what does it include that is different from all of the points of the first? Seems extra extra gatekeeping.

Thank you!

[REDACTED]


I suspect they want 2 independent letters and yes follow the format from the first letter.

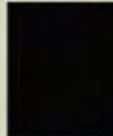
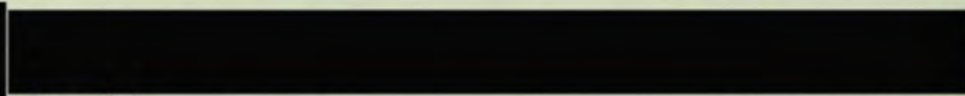
Comment

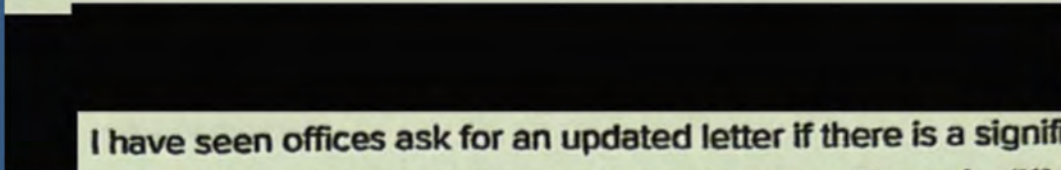
[REDACTED]


Hi! My understanding is that generally two letters are only required when they're for gender-affirming bottom surgery. I wonder if per chance this is being requested due to the teen being 17 so not yet a legal adult. I agree that it absolutely seems like extra gatekeeping. May I ask where this teen is located? If they need letters from two

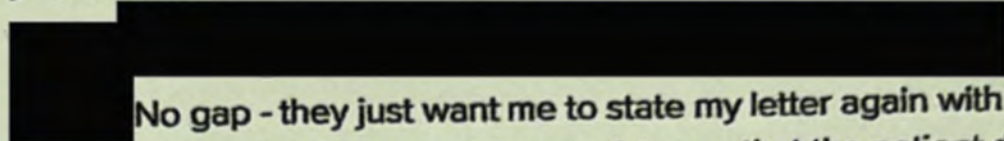
different providers, I believe there are quite a few of us who are willing to provide a session and letter pro bono if that's what's in the best interest of the client...

 Comment

   
Exactly!

  
I have seen offices ask for an updated letter if there is a significant gap between the first letter and time of surgery. The only difference is the date and any updates or a statement of no additional identified matters.

 Comment


  
No gap - they just want me to state my letter again with a different date. I guess for consistency, that the patient did not change their mind 2 weeks later (ugh!).



Hi [REDACTED]


I've had similar requests from surgeons and insurance companies for top surgery for anyone under 18. The explanation given to me was because the client was a minor and they wanted evidence that the two assessments were done independently and not at the same time (i.e., not "rubber-stamped"). An example was a rejection I got when submitting a letter that my PhD colleague co-signed. There was a brief period when one letter signed by both was sufficient but I'm no longer able to do that at this time....

[Read more](#)

 Comment

[REDACTED]  
[REDACTED]  
[REDACTED]  
Super helpful, thanks!

[REDACTED]  
Too many times than I care to remember! Agree it seems like extra extra gate keeping. As far as I can tell, there is nothing additional from the first— just two mental health professionals writing nearly the same thing...

 Comment

[REDACTED]  
(Assuming this family is using health insurance to cover the costs of surgery) Do you know which insurance they have? Some insurers require two letters for all surgeries - many surgeons are also requiring a letter from the hormone provider to document length on hormones, thus, demonstrating to an insurer that the member has fulfilled any time on hormones requirements. I suspect that your client needs a letter from a second provider. If you know the insurer's requirements, you may be able to push back and help your client advocate with the surgeon if it's unnecessary. I suspect what will be needed is a letter from a second provider, or potentially, your initial letter co-signed wit...

[REDACTED]  
[REDACTED] - there is a surgeon that I know who requests two letters also for top surgery. I think sometimes it can be a long time from the time someone originally wrote the letter (especially during covid), but it is my understanding that the letter is written essentially the same way as the first. I agree it does feel like they are gatekeeping, so we just make sure our patients are aware of these expectations.

Comment

[REDACTED]  
Hi everyone! Thanks for your replies. To clarify, insurance wants 2 letters stamped with 2 different dates from the SAME masters-level clinician (me!). I write letters all the time through GALAP (<https://thegalap.org/>) and am aware of 2 masters levels clinicians for bottom-surgeries. I was stumped with this one because they want me to write 2 different letters. [REDACTED] nailed it I believe with their answers! Thanks all.

Comment


[REDACTED]  
[REDACTED] Sounds like a mess! This definitely sounds like extra gatekeeping. Do you feel comfortable disclosing which insurer this is? You could report the insurer to your local state's insurer regulator for their clinically unsound coverage determination requirements.



[REDACTED]


In my experience working with the transgender community for over twenty years, usually when a second letter is requested, it is to be written by an independent qualified professional who conducts a one or two visit consultation to confirm the treating professional's diagnosis of Gender Dysphoria and opinion that the patient is eligible and ready for Gender Confirmation Surgery. While many surgeons will accept a single letter for top surgery my guess is that this particular surgeon may want to make absolutely certain that surgery is indicated for this patient because of his young age....

Read more

 Comment

[REDACTED]

I have not heard of a request for two letters from the same provider for the same procedure before. The only thing I can think of is to show that the status of the client did not change over time?

 Comment

[REDACTED]

[REDACTED]

Same thought, thanks!

[REDACTED]

[REDACTED]

I'm [REDACTED] (they/them) and I provide professional consultation

specifically regarding letter writing and assessment case conceptualization. If you're interested in consultation with a provider of lived experience, I'm happy to chat further. I've written quite a few second letters and have written letters for minors as well.

Comment

[REDACTED]

I have had surgery offices say 2 letters were requested by the insurance company. Same surgeon has not always requested 2 letters, thus, it seems insurance co controlled. Also patient has inquired and insurance company did not request 2. It seems to vary.

Comment

[REDACTED]

I am on the surgeon's side of things.

The first thing I would do is ask for a copy of the plan documents' section on Transgender Benefits. See what the letter requirements actually are, and then follow them to a T.

With a 17yr old, I also find it helpful to include info pertaining to the needs of the 17yr old (who will soon be 18) to begin their new adult life with the "first part" of their medical transition complete, why starting university with top surgery done is imperative, how reducing harm...

Read more

Comment

[REDACTED]

Thanks so much [REDACTED]

[REDACTED]

All I can say is that I've had different states, insurance companies and providers ask for different things. For example, I learned that CA has a particular time frame in which the letter needs to be written. Not so in NY. I have not found much consistency in the letter writing process. Very interesting discussion.



d) A WPATH member states that surgery is necessary for mental and physical health despite insurance denial, seeking a way to circumvent the insurance policy

**Insurance Denial**

[REDACTED]

I have a client who was recently denied FFS from her insurance carrier, Geisinger Health Plan. The denial letter indicates for the request to be approved that she must be on HRT for at least 1 year.

Is there any way around this policy or wording I can use to help her appeal? The client has no interest in HRT at this time, and I certainly don't agree with an insurance plan telling her that she must be on HRT to obtain medically necessary surgery for her physical and mental health, along with her safety.

I greatly appreciate any support/suggestions!

September 14, 2021

[REDACTED]

Normally if we have a patient that isn't taking hormones we have to explain why in the letter and give justification regarding the person's lived experience.

September 15, 2021

Comment

[REDACTED]

A few things to consider:

1. For clients/patients needing a letter and is not/does not plan to go on hormones, you can write something like, "at this time, gender affirming hormone therapy is contraindicated in her treatment for gender dysphoria and does not align with her goals for reducing symptoms." Recommend citing GHP's policy, link below and WPATH SOC 7. Erring on less is more.
2. Generally, it would appear that Geisinger Health Plan's standard policy on gender affirming care explicitly excludes FFS procedures, so possibly an uphill battle that may result in an external appeals process, removed of the reason cited by the coverage determination letter. This policy


may not apply to your client's specific plan, so it may require further inquiry to confirm which policy applies.

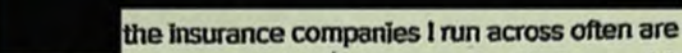
3. Anticipating a second denial, highly recommend referring your client to a Consumer Assistance Program that assists residents with handling insurance appeals - every state maintains their own programs, some have discontinued state funded assistance, but worth seeking out.

4. Appeals processes are exhausting for clients and providers involved - it may be helpful to acknowledge how these processes may be affecting your client as many people report feeling demoralized while working through them, regardless of what types of advocacy you may be able to offer as a provider.

Geisinger Health Plan Policies and Procedure Manual (<https://www.geisinger.org/-/media/OneGeisinger/Files/Policy-PDFs/MP/301-350/MP307-Gender-Dysphoria-and-Gender-Confirmation-Treatment.pdf?la=en>)


September 15, 2021

 Comment

 the insurance companies I run across often are receptive when you indicate why FFS is appropriate without HRT...and quoting the SOC page 60 - "5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated for the individual)."

Appeal!

September 19, 2021

 Comment



10) LIVED EXPERIENCE GUIDELINES FOR TRANSITION

a) *WPATH members discuss potential vaginoplasty in elderly patient*

DISCUSSION

**12 mo lived gender requirement for gender affirmation surgeries**

2,712 Discussion Views  
7 Responses

I have an 79yo assigned male at birth patient with a lifelong nonbinary/female gender identity requesting a limited depth vaginoplasty. Patient does not meet the 12 mo lived gender requirement of WPATH SoC version 7 because they are not comfortable socially transitioning at this age in front of their children and rural community. Does anyone know whether SoC v8 will soften the 12mo lived gender requirement? We'll find out end of Dec when it comes out, but at age 79, time is of the essence.

Submit

Does "12 months living in gender role" necessarily have to be interpreted as "12 months of being out as trans in absolutely every possible setting"? Plenty of trans people socially transition in some settings and present as their assigned gender at birth in other settings for logistical reasons (e.g. employment discrimination, family issues). I'm assuming the patient has been "living" in her identified gender at home and/or to certain select people (healthcare professionals? support group? trans friends?) for a long time, even if she's not out to the majority of the people in her community.

Comment

Hi [REDACTED] I'm happy to consult further about this, but the 'lived gender requirement' isn't a requirement of someone needing to be meeting whatever gender expression we deem they are supposed to to 'pass,' but actually that they have been affirming their gender in whatever way feels safe and accessible to them at this time for over a year. So if someone has felt solid in who they are and what they need for their body for over a year, and has been affirming that to themselves or others, expressing in whatever ways they desire/feel safe, and they state they need gender affirming genital surgery to further affirm their gender and allow them to alleviate some dysphoria, then that does fulfill the criteria. Feel free to direct message me in [REDACTED] if you'd like to consult further.

Comment

[REDACTED]  
I second the comments above and interpret the 12-month lived gender requirement in a much looser way. As long as the patient themselves has identified as their current gender for the past 12 months, the specific ways/settings in which they have expressed this matter much less to me when it comes to my letters of support. If specifically asked, I may include a statement attesting to limitations of the lived gender requirement in my letter (e.g., "She is limited in her ability to express female identity outside of the home due to the rural/conservative nature of her employer and community).

Comment

[REDACTED]  
Very interesting, following to hear from the experts. Is this the patient's first gender affirming procedure? Are they on hormone therapy? Are they dysphoric and otherwise meet all WPATH criteria?

Comment

[REDACTED]  
That was SOC6...no requirement for RLE in SOC7.

Comment

[REDACTED]  
The SOC7 are meant to be flexible guidelines. I have successfully referred a number of patients who were not out for surgery, explaining why they were unable to meet this Lived Experience guideline. It's fine to refer her with the current guidelines. You don't have to wait for SOC8.

Comment

[REDACTED]  
I understand the SOC to be flexible so that we can make clinical assessments and determinations about what fits best for the patient and their gender goals.

[REDACTED]

Very interesting, following to hear from the experts. Is this the patient's first gender affirming procedure? Are they on hormone therapy? Are they dysphoric and otherwise meet all WPATH criteria?

Comment

[REDACTED]

That was SOC6...no requirement for RLE in SOC7.

Comment

[REDACTED]

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Comment

[REDACTED]


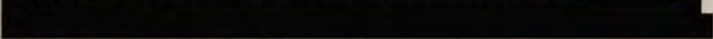
I understand the SOC to be flexible so that we can make clinical assessments and determinations about what fits best for the patient and their gender goals.





11) HYGIENE CONCERNS


a) WPATH members discuss lack of hygiene in a patient after hormone replacement therapy (HRT)

DISCUSSION o


 **Hygiene concerns in an early transfemale**  


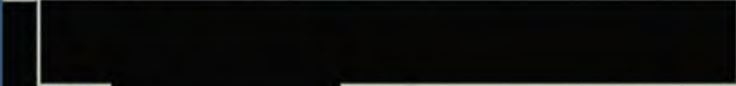

 851 Discussion Views  
 2 Responses

I have a patient who is choosing not to change clothes, has not showered and has worn the same clothing since a follow up nearly a month ago. I'm not certain if this is due to dysmorphia but it may well be. She is also failing to shave her face so now has quite a lengthy beard. This is her first month of HRT. Has anyone else experienced this or have suggestions to approaching this issue?

Hi 

I am a family practice provider. Seems to me the lack of hygiene may indicate depression. The shaving is likely less gender and more hygiene and depression but I'm not a mental health expert. In my 8 years experience I have never experienced this response at the first followup. I would be investigating if there is uncontrolled depression. Hope it helps.

 Comment

 Dear 

I'd like to address some of your concerns if I might.

1. Safety first; is this client safe? Do they have stable housing, or shelter, an income, eating regularly? Are they subject to any abuse, assault, bullying, or harassment?



2. Secondly, when you say "early", is this early in the therapeutic process, early in transition, or early in your work with her? I ask because each requires different answers. I'm going to answer "early in work with you." You've diagnosed GD or were referred by someone who had, yes? You've probably done an assessment and BDI; is this person experiencing elevated levels of frustration, anxiety, or depression? Do they have a history of suicidality? There are so many triggers that can push the associated symptomology of gender dysphoria into crisis; have any of these occurred?

3. Regarding the unchanged clothing, does this person have much of a wardrobe? It is very common for Trans folk to maintain THREE wardrobes, particularly Trans women, one of male drag for situations where they are not out, one of female garb matching their gender identity for spaces they're able to present authentically, and garments, usually female, but of an androgynous cut that may be worn anywhere. She may not have many clothes in the second category. She may be very early in transition, still struggling with self-acceptance and cycling through stages of clothing purges.

4. Poor hygiene instantly brings to mind safety again, as in risk of self-harm, elevated depression, suicidality, but also safety as in no stable housing or access to shower facilities or laundry, or not out in housing situation and therefore constrained in dressing space and options due to fear of violence.



5. Has she been diagnosed with dysmorphia? GD diagnostics do contain elements of dissatisfaction ranging to disgust with natal biology matching gender designation at birth rather than actual experienced/lived gender/gender identity but aren't usually referred to with the term "dysmorphia" unless that is a separate diagnosis specific to particular areas of anatomy. Usually, gender dysphoria includes a critical focus upon genitalia or any prominent and visible secondary sex characteristic of GDAB biology. For Trans women, this includes beard shadow, shoulder width, hand size, chin prominence, laryngeal promontory, or other features which may be difficult to alter or conceal and therefore particularly stressful at this stage.

6. Again, with the cessation of shaving, does she have access to adequate shaving supplies and safe space to use them? Or is it possible that this is part of a struggle with self-acceptance and might represent a "flight into masculinity" paradigm? Also, remember race can figure as well. Black Trans women often have different issues managing beard growth, skin appearance, hair and removal methods, and may require elements that could be expensive or unavailable, such as specialty depilatories suitable for multiple skin types.

7. Frequently in the very early days of GAHT, folks experience a boost of positivity, hopefulness, find it easier to regulate, and often describe this concrete and tangible action forward as "gender euphoria." This can be true even if circumstances such as work or family may prevent them from presenting in their experienced gender and may have to continue living part or full time in their GDAB gender presentation.

I hope some of these observations prove useful.

12) NON-STANDARD MEDICAL PROCEDURES

a) *WPATH members discuss appropriate standards of care for nonbinary patients, particularly when they request non-standard procedures*

**Standards of Care for Non-Binary Patients**  
By **Thomas Satterwhite** [Redacted]  
Founder/CEO

3,585 Discussion Views  
17 Responses

How do we come up with appropriate standards for non-binary patients?  
What best practices and standards are you following in your experience?

I've found more and more patients recently requesting "non-standard" procedures such as top surgery without nipples, nullification, and phallus-preserving vaginoplasty.

Submit

[Redacted]

Thank you for raising this topic, Dr. Satterwhite. I look forward to seeing further input from colleagues and how the forthcoming SOC 8 touches on this topic. It would be important to offer additional information about foreclosed options when performing a procedure that removes tissues that might be wanted for further reconstruction- ie, penectomy only, discarding nipple grafts, etc.

While it might be true that patients who are nonbinary are more likely to make these requests, these procedures are options also selected by those with binary gender identities. Likewise, nonbinary patients...

Read more

Comment

**Thomas Satterwhite** [Redacted]

Thank you for the very informative response! I like the term "low frequency request," though over the years, I've found the requests increasing in my practice. From my perspective as a surgeon, I am quite comfortable performing procedures that



are of a "low frequency" (ie, variations in top surgery; as well as bottom surgery, such as phallus-preserving vaginoplasty and nullification) on a fairly frequent basis (and I openly bring this up in my own website and patient materials, so prospective patients will feel welcome in bringing up any surgical goals to me), but it's been rather difficult for me to find other surgeons with the same comfort level who are willing to share their experiences. From a surgical perspective, it would be wonderful to collaborate with colleagues to optimize surgical technique and outcomes. I appreciate the discussion that has been generated.

[REDACTED]

I am not sure whether we need new standards of care or just a different way of looking at gender that is not through a cisgenderist gaze. If adult patients have body autonomy, what is the issue with having top surgery without nipples, for example? Surgical tattoos can help if the patient changes their mind later. I'm not a medical doctor but I do wonder whether it's what is considered standard or non-standard procedures that need to be reconsidered, rather than having separate SoC for non-binary patients. Just a thought from a non-binary mental health provider who has over a decade of experience serving trans, non-binary, &/or gender expansive populations.

Comment

[REDACTED]

YES!



I think it's important to recognize that not all people requesting non-standard procedures are nonbinary, and vice versa.

De-gendering procedures (while still being explicitly trans-inclusive) and taking a patient-centered approach regarding the type of procedure and other specifications is best, from my perspective. When you group certain procedures as "nonbinary" and others that are for binary genders, you risk patients feeling as though they have to ascribe to a certain category to get what they need.

Comment

Yes, this is a great reminder/approach!

This is an important point, thank you for making it

I think one of the lessons of the failure of gatekeeping-type approaches in this space is that when people are not free to define for themselves the goals and (so far as possible) timeline of their medical transitions, the risk of post-treatment regret is increased (albeit proportional to the teeny tiny baseline risk). For example, if a hysterectomy is presented to patients as a necessary aspect of a binary trans male transition, even if that surgery would have also been the patient's ultimate choice in the absence of that pressure, the lost autonomy in the decision will make the patient more likely to feel it as a loss, rather than/as well as/after feeling it as a

relief. It also makes it much more difficult to establish a trusting therapeutic alliance, eroding the ability of the patient to ask questions and explore possibilities.

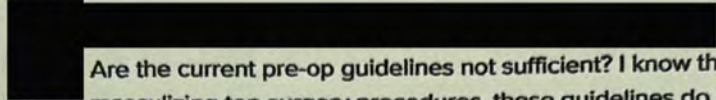


Thomas Satterwhite [REDACTED]

Thank you for pointing this out, [REDACTED] I wholeheartedly agree with your comments; I had written my initial question too hastily and too thoughtlessly. With every patient I operate on, I always take a patient-centric approach and I let my patient lead the journey (not me). And you are correct, of course—gender identity has nothing to do with one's gender expression and choice of surgical procedures. What I was trying to (clumsily) ask is: since there are established pre-op guidelines for "standard" (and I hate using this word) procedures such as vaginoplasty, phalloplasty, and mastectomy, how will we all (and the SOC) evolve to appropriately establish standards for "non-standard"...

[Read more](#)

Comment



Are the current pre-op guidelines not sufficient? I know that for masculinizing top surgery procedures, these guidelines do not state whether or not someone should have nipples, what type of procedure would be most appropriate given chest size, or whether or not body contouring techniques are needed to address gender dysphoria.


My concern with creating a new set of guidelines for procedures that don't neatly fit into the currently established taxonomical classification is how new guidance may create new bureaucratic processes to handle at health care systems coverage level. In the US, our insurance systems still (largely) rigidly define what surgical procedures are appropriate for specific bodies (typically, based on binary sex or gender identity categories), and creating a new process for procedures that are less common will likely generate more challenges for patients and their letter writers.

That being said, what would you hope that creating new guidelines for these procedures would accomplish?



[REDACTED]

Is "non-standard" procedures the best term to use? They may become standard in the future....any more possible terms that could be used to describe these kind of procedures without having to describe them?

 Comment

[REDACTED]

Variations of gender affirming surgeries.

[REDACTED]

I think an approach that might help would be reframing medical and surgical interventions as responsive to an individual's need related to their own specific "embodiment of gender" rather than the current terminology. The entire field of gender care is going to be inevitably overhauled by younger people (thankfully) and we will need to adjust our lens regarding interventions being responsive to the poorly defined "gender dysphoria."



**Thomas Satterwhite** [REDACTED]

I look forward to hearing your talk! Over the years, the types of operations I've performed have evolved based on my patients goals and wishes—for top surgery, I've performed mastectomies without nipples, or have created chests with varying degrees of remaining breast tissue, or created incision patterns specific to my patient's wishes. For bottom surgery, I've performed minimal-depth vaginoplasties (vulvoplasties), phallus-preserving vaginoplasties, and nullification procedures. I'm quite comfortable tailoring my operations to serve the needs of each patient. We've put together a...

[Read more](#)


[REDACTED]

Hi Thomas,

I'm so glad to see this question posed. I think we are going to see a wave of non-binary affirming requests for surgery that will include non-standard procedures.

I have worked with clients who identify as non-binary, agender and Eunuchs who have wanted atypical surgical procedures, many of which either don't exist in nature or represent the first of their kind - and therefore probably have few examples of best practices and...

[Read more](#)


 Comment

[REDACTED]

I have experienced that pushback from both trans and non-binary patients as well over the last year compared to any time prior. Pushback means the need to justify the requirement for a letter from a mental health professional.

[REDACTED]

I've found this whole discussion incredibly useful.

 Comment



DISCUSSION

**Gender Nullification Surgery**

1,746 Discussion Views

6 Responses

This morning I had my first patient ask about Gender Nullification Surgery.

I have no experience with this procedure, what the recovery is like, what the scars are like or who performs it. The patient is AMAB.

Any info is appreciated.

Submit



**Rajveer S. Purohit**

This is an uncommon but a very important topic (in my opinion). I found it really important to discuss with patients exactly what they want - e.g. orgasms or not, sitting to urinate, etc. Getting the letters of psychological support are particularly important in this case. That said, what I have done in the past is a total penectomy with neurovascular pedicle preservation and burial of a "neoclitoris" so patients can continue to have orgasms - if they wish - a segment of the bulbar urethral remnant is preserved and brought out as a perineal urethrostomy and sutured to a u-flap posteriorly. Anteriorly, the skin above the phallus is developed as a flap and mobilized down to the...

Read more

Comment


Found this link. I have not had a patient request this either.

Comment

The Crane Center website also has info on nullification surgery.

[REDACTED]

I actually just came here to ask about this. I had an AFAB client bring it up to me today and I had never heard of it. I did find a couple of doctors via Google who provide it, but I would love to have more basic info about it!


 Comment



**Thomas Satterwhite** [REDACTED]

Hi [REDACTED] This is a procedure that we perform in our practice (Align Surgical Associates). We are based in San Francisco. We've been able to consistently get insurance coverage for many of our patients. Our website contains information on the procedures, and we do have information/photos on post op results (on "nullification" and other variations in genital gender affirming surgery) that can be viewed here: Gender Expansive Bottom Surgery (<https://www.alignsurgical.com/gallery/gender-expansive-bottom-surgery/>)


...

 Comment



**Daniel D. Dugi** [REDACTED]

We also offer this at OHSU in Portland, Oregon. Incision/scar pattern depends on patient choice of approach—we offer two approaches depending on patient goals. Haven't had a problem getting insurance coverage so far.

 Comment



Non-standard surgeries and the logic of trans health

WPA H WPAH Member Forum

I hope everyone had a lovely time at the conference; it was a pleasure meeting many of you!

I wanted to make a post to open a discussion on a topic that has been subject of some tensions at the conference. Providers have delightfully presented about new techniques that are being developed to serve trans people whose embodiment goals do not fit dominant expectations—mastectomies without nipples, mastectomies for people who do not want breasts from estrogen, vagina-preserving phalloplasties, etc.

These new 'non-standard' surgeries are for many a fantastic development. Some, however, are concerned by them. People's discomfort with non-standard surgeries often turn on them being 'weird', them reflecting 'uncertainty' or 'lack of commitment' to transition, or them risking the ire of conservatives.

When thinking about non-standard surgeries, I think it is crucial for us to go back to the basics of trans health. Why do people seek out trans health? It's to have a body that feels comfortable to them, that feels like them, that feels like home—or, at least, as close to it as possible. Trans health is not and should not be about creating bodies that are socially

acceptable, bodies that do not challenge cisnormativity. Trans health is about bodily autonomy, not about normalizing bodies. We didn't reject the idea that you can't change your gender only to double down on the idea that gender is binary and defined by genitals!

Conservatives are scary and I understand the fear that non-standard surgeries will be weaponized against access to care. However, it is far from clear that offering individualized surgeries will lead to the downfall of trans care. First, they already think all trans surgeries are mutilation so non-standard surgeries aren't a big difference or religious conservatives. Second, individualizing surgeries reinforces our counter-narrative that trans care is not about pushing people into fitting stereotypes but about finding what fits each person best. I also don't think it would be fair to throw those who want non-standard surgeries under the bus—they're not less important or less deserving because what they want is different. Isn't making space for difference why we got into trans health in the first place? And if we reject those surgeries for being 'weird' or politically unpopular, can we trust ourselves to stand up for the other subgroups that religious conservatives target?

Food for thought.

Add to this discussion either by replying to this email or by using the button below.

Reply To Discussion

Advisors of the Community:

Marci L. Bowers

13) LACTATION CONCERNS

a) A WPATH member discusses risk in providing a trans patient with lactation capabilities

**DISCUSSION**

**Lactation in a transwoman**

1,081 Discussion Views  
4 Responses

I have a 30 year old transwoman who wants to lactate "just to experience it": i.e., this is not to nurse an infant. Protocols to do this involve increased estrogen and giving progesterone, as well as domperidone (technically not approved here in USA). I have some ethical issues with this, as this is not without some risk. Interested in hearing comments.

Submit

I also have ethical concerns in this case. If a cis woman came to me with this wish, I would refuse therapy. After all, we are talking about a medical intervention that is not necessary.

Comment

I have also had success with metoclopramide TID + pumping along with estradiol, not necessarily at an increased dose depending on levels. There is some risk for tardive dyskinesia with this drug, but it is FDA approved and more easily accessible than domperidone.


Comment

I am an ethicist, not a physician. I agree with you that there is a questionable reason for this medical intervention. You are not a technician; you are a professional to whom society gives certain privileges in exchange for your prudent use of resources, your




commitment to interventions where benefits outweigh risk and to "at least do no harm." I understand your patient's desire to experience lactation as one function of her womanhood. But that is insufficient reason, in my estimation, to intervene medically. Our colleague [REDACTED] put it well—if a cis woman requested it, they would refuse....

[Read more](#)

 [Comment](#)

[REDACTED]  
[REDACTED]  
[REDACTED] i have never had this request but I have had patients who have expressed a wish to lactate so that they can nurse/co-nurse a child. I think there are few studies of this being done successfully but would be interested to know more.

In regards to your patients request I would have huge concerns about the ethical implications of complying with such a request.

 [Comment](#)

Submit

b) A nonbinary female expresses a desire to induce lactation and take Cialis

**Cialis or Viagra and lactation**

536 Discussion Views

Self-identified non-binary female (AMAB) hopes to induce lactation for their 7-month-old; also interested in Cialis. I'm seeking research or clinical experience on the safety of Cialis (tadalafil) or Viagra (sildenafil) during lactation? In LactMed I see, "Limited data indicate that sildenafil and its active metabolite in breastmilk are poorly excreted into breastmilk. Amounts ingested by the infant are small and would not be expected to cause any adverse effects in breastfed infants". Thank you!

Submit

14) NON-BINARY HEALTHCARE FOR MINORS

a) WPATH members discuss a nonbinary 13-year-old patient requesting HRT

**Best practice for 13yo non-binary requesting T**

1,601 Discussion Views  
2 Responses


Hello folks,  
I have an incoming 13yo (soon to be 14yo) who has identified this past year as non-binary, referred to me for assessment to start testosterone (per child's request). Thoughts? I was under the impression that is more the exception to start for kids under 16, not the norm and ideally the adolescent be at least 16. It has been a while since I've had younger clients seeking hormones and wanted to make sure I am up to date on information, guidance and best practices.  
A possible complication, sounds like there is some purposeful malnutrition and restrictive eating for "a more non-binary appearance".  
Thank you in advance.

Submit

The current SOC actually removes the age requirement all together and recommends not starting until the adolescent is reasonably able to provide informed consent, the age of which will be different person to person. Individual practices may vary, but you can provide that assessment and then the prescribing clinician and inform families of their own practice.

Comment




  
You bring up some very interesting issues. At what age should transition begin, and what are the problems associated with possible detransition is a person who is so young.

I usually recommend that the person be living as the other sex for 6-12 months since they may find that they are uncomfortable with the sex that they feel is appropriate. Also, they need at least one supportive parent involved.

It is very difficult to ask that they wait until age 16 because by then they will be dealing with menstrual periods and complete breast development. Waiting appears to increase the rate of suicide attempts.

After much experience as a pediatric endocrinologist, I would not rule out treating if the person is living as a male and is convinced that transition would be correct for him.

 Comment



15) CAUSE FOR TRANSITION AND EXPLORATORY THERAPY

a) A WPATH member questions if there is a root cause driving transition

**What is 'exploratory therapy'?**

2,482 Discussion Views  
3 Responses

We are increasingly seeing references to exploratory therapy a prerequisite to transition-related medical interventions. Oftentimes, although not always, this is coupled with Littman-esque concerns that youths are transitioning due to trauma, social pressure, or internalized misogyny and homophobia. Beyond the idea that potential 'causes' of the trans identity should be explored, I have rarely seen extensive discussions of the parameters of exploratory therapy. For those who practice I had a few questions. I acknowledge that they are leading questions, but hope you will nevertheless make a good faith attempt to answer them as fully as possible:

1. What do you do if the patient refuses to explore with you? Do you refuse them gender-affirming care, even if it may be necessary?
2. How long does the exploratory therapy last? How do you know if it has gone on long enough? Do you go until you find a 'root cause'?
3. How do you distinguish between, e.g., trauma that caused someone to be trans and trauma that a trans person happens to have? Do you trust the patient's beliefs? Would you equally trust a patient's view that it is not grounded in trauma?
4. If you find that self-identification is rooted in, e.g., trauma, how do you assess whether this response is adaptive or maladaptive, and whether the person can safely be encouraged or helped to re-identify with the gender assigned at birth? If this proves unsuccessful, would you ever consider recommending access to gender-affirming care? Under what conditions?

5. If a patient re-identifies as cisgender, do you wind-down the therapy or do you continue at the same pace to ensure their re-identification is genuine and not a coping or adaptive response? Why or why not?

6. Relatedly, do you consider self-identification as transgender more suspect or deserving of exploration than self-identification as cisgender? Why or why not? How is this reflected in exploratory therapy?

7. Is there any evidence that exploratory therapy leads to better outcomes, however you define them, or that it can successfully identify youths who aren't 'truly trans,' youths whose identification is maladaptive, and/or youths who would be harmed by accessing gender-affirming interventions?

8. Do you believe that transition-related medical interventions such as hormones can be offered in parallel to exploratory therapy either as a means of reducing present gender dysphoria or as a way of helping the individual explore their gender and whether gender-affirming care is right for them? Do you think social and medical transition being temporary is an inherently undesirable outcome? Why or why not? Is this related to an intuition that bodies that have undergone medical transition are less desirable and should be avoided if possible?

9. What do you make of the distress of the numerous youths who are 'truly' trans, who we have reasons to believe are a strong majority and will experience ongoing distress during? Based on the recent Littman study, the high end of non-disclosure of detransition to clinician is around 75% and the high end of detransition estimates is around 3%. Even assuming the correctness of these higher bound estimates, we would still have 88% of individuals not detransitioning.



9. Given your concern about precipitated and premature affirmation as a foreclosure of gender identity and exploration, what are your thoughts on encouraging puberty blockers more broadly to all questioning or even perhaps all cisgender kids? Would your answer change if we were 100% certain that puberty blockers had no long-term side effects?

10. Do you believe that such exploratory therapy can create psychological and emotional pressures to re-identify with the gender they were assigned at birth?

11. Do you believe that such exploratory therapy can create psychological and emotional pressures to lie, misrepresent, or otherwise engage in the therapy in bad faith so as to ensure access to sought interventions? Do you believe this could lead patients to suppress doubts and worries and, as a result, make less-than-informed decisions on accessing gender-affirming care?

Thank you ahead of time for your answers.

I would be really interested in where these ideas come from, the references. I have a parent of an 18 year old client who is demanding this verbatim. Mind you the client is 18, so the parent can't demand a single thing.

Comment

I deeply appreciate you and the work and thought that went into these questions. I am likewise concerned about these issues and share your deep concern regarding the children and adolescent sections of the SOC 8. It's perhaps naïve, but I expected the guidelines to advance possibilities and as I read it, many parts feel more restrictive than what's in place, even in my more conservative part of the country.

Comment

I would like to thank [REDACTED] for this timely article. We (the LGBTQ2I community) are not progressing out of a particular 'hole' we seem to be trapped in...this deep depression of ignorance. I am a scientist, and have come to understand profoundly that there exists reasons for everything being how everything is, including that "T" word...transition. I stress here the word "reasons" as opposed to "causes". There is no "cause" for transition...there are reasons and the word "choice" is not applicable. So....if it is not by "choice" then it is by.... what? When we answer that question adequately then the gatekeeping will stop, and not before. People are born gay...they do...

[Read more](#)



16) FERTILITY ISSUES

a) *A WPATH member seeks resources for infertility treatments*

**Clomiphene for trans feminine infertility, any experiences or resources?**

[REDACTED]

👁 1,256 Discussion Views

Does anyone have any resources or citations for the use of clomiphene for azospermia despite 6 months off estrogen for a trans feminine patient who desires return of fertility? Patient is aware that it is off label use. Other endocrine labs pending at this time. Thanks!

17) RESOURCES FOR MINORS ON TRANS HEALTHCARE

a) *WPATH* members discuss a school psychologist searching for gender resources for students

**Resources on Gender**

[REDACTED]

I was contacted by a psychologist who works at a school (K-8) and is looking for general info on gender. The purpose is to help their students (and parents) understand what gender is and to allow them the freedom to explore. In speaking to her, I realized that my plethora of resources is almost all for kids who already identify as trans. Does anyone know of any resources for children that help them understand gender, or that answer questions parents may have about gender?

February 14, 2022

Submit

[REDACTED]

[REDACTED] from a few years ago, and I now work with the Trans community as a woman of trans experience. I have put some resources together that you might find helpful. They are not targeted at children, but would be helpful for parents and teachers. [REDACTED] Gender Education ([https://\[REDACTED\]gender-education](https://[REDACTED]gender-education))

I also have a book on transitioning coming out soon. I hope you can find something helpful.

February 23, 2022

Comment

[REDACTED]

These 2 books are great.

The Reflective Workbook for Parents and Families of Transgender and Non-Binary Children: Your Transition as Your Child Transitions ([https://www.amazon.com/Reflective-Workbook-Families-Transgender-Non-Binary/dp/1787752364/ref=sr\\_1\\_4?crid=9FC7SQ8VHUWJ&keywords=maynard+transgender&qid=164565](https://www.amazon.com/Reflective-Workbook-Families-Transgender-Non-Binary/dp/1787752364/ref=sr_1_4?crid=9FC7SQ8VHUWJ&keywords=maynard+transgender&qid=164565))

The Reflective Workbook for Teachers and Support Staff of Trans and Non-Binary Students ([https://www.amazon.com/Reflective-Workbook-Teachers-Non-Binary-Students/dp/1787752178/ref=sr\\_1\\_5?crid=9FC7SQ8VHJWJ&keywords=maynard+transgender&qid=1645653115&prefix=maynards+transgend%2Caps%2C292&s=8-5](https://www.amazon.com/Reflective-Workbook-Teachers-Non-Binary-Students/dp/1787752178/ref=sr_1_5?crid=9FC7SQ8VHJWJ&keywords=maynard+transgender&qid=1645653115&prefix=maynards+transgend%2Caps%2C292&s=8-5))

February 23, 2022

Comment

[REDACTED]

For teens/pre-teens, I like to use the Gender Quest workbook ([https://www.amazon.com/Gender-Quest-Workbook-Exploring-Identity-ebook/dp/B01BRSC3WE/ref=sr\\_1\\_1?crid=3ILMEGBOK34I3&keywords=gender+quest&qid=1645652708&s=digital-text&prefix=gender+quest%2Cdigital-text%2C109&s=1-1](https://www.amazon.com/Gender-Quest-Workbook-Exploring-Identity-ebook/dp/B01BRSC3WE/ref=sr_1_1?crid=3ILMEGBOK34I3&keywords=gender+quest&qid=1645652708&s=digital-text&prefix=gender+quest%2Cdigital-text%2C109&s=1-1)) with clients to guide our discussions. For younger children (although I don't personally work with this age group), The Gender Identity Workbook for Kids by K. Storck would be my recommendation.

February 23, 2022

Comment

[REDACTED]

Hi [REDACTED] for parents I would recommend my book, How To Understand Your Gender (<https://bookshop.org/books/how-to-understand-your-gender-a-practical-guide-for-exploring-who-you-are/9781785927461>). I have been told that it's a good resource for parents. It's definitely not just about trans people or trans issues but rather a guide to understanding gender for people of any gender(s). It is also suitable for high school students but not really K-8, although I know some middle-schoolers who have enjoyed it.

For K-8, I would recommend the following books:

The Big Book of LGBTQ Activities (<https://us.jkp.com/collections/gender-diversity-gender-diversity-pid-906/products/the-big-book-of-lgbtq-activities>)

The Every Body Book (<https://us.jkp.com/collections/children-s-books-gender-diversity-pid-816/products/the-every-body-book>)

The Pronoun Book (<https://us.jkp.com/collections/children-s-books-gender-diversity-pid-816/products/the-pronoun-book>)

For younger children. Who Are You? (<https://us.jkp.com/collections/children-s-books-gender-diversity-pid-816/products/who-are-you>)

I hope this is helpfull

February 23, 2022

Comment

[REDACTED]

I just learned of this resource, which may be helpful for your needs. There's a resource page for parents and supportive adults which gives some basic info: TYFA - Parents (<http://imatyfa.org/parents.html>)

18) EVALUATING DYSPHORIA SEVERITY

a) *WPATH members discuss finding validated measures for gender dysphoria severity*

**Dysphoria severity**  
 [REDACTED]

👁 2,287 Discussion Views  
 ↩ 3 Responses

Good day, is anyone out there using a validated measure for assessing dysphoria severity in routine clinical care? If so, what would that be and how have you found it useful in your practice? Thanks.

[REDACTED]

These are perhaps more research-oriented, but I like the gender distress and positivity scales developed by the Trans Youth CAN! team: <https://transyouthcan.ca/project-documents/#data>. I particularly appreciate the attention to gender positivity, not just distress, and think that could be better incorporated into clinical practice. (https://transyouthcan.ca/project-documents/#data. I particularly appreciate the attention to gender positivity, not just distress, and think that could be better incorporated into clinical practice.)

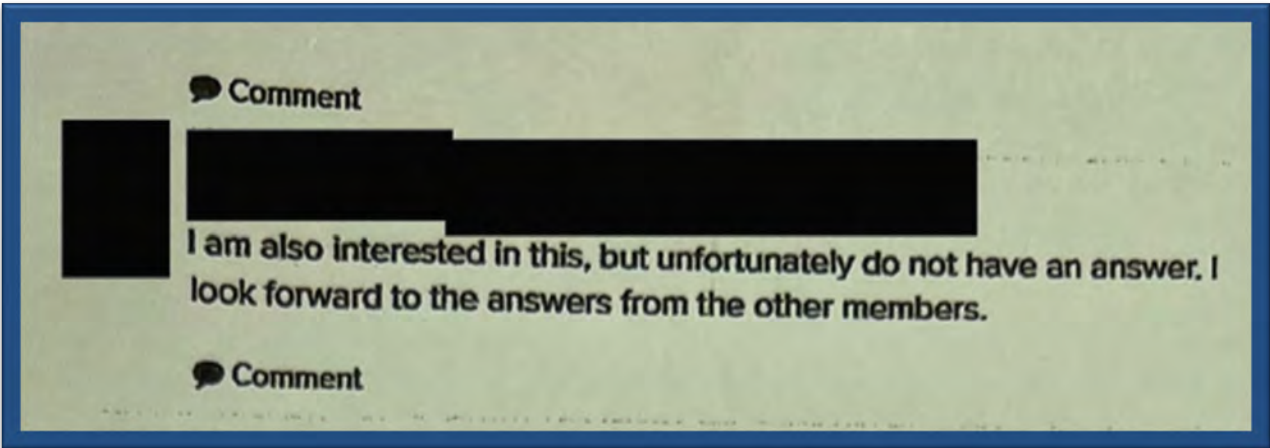
💬 Comment

[REDACTED]

[REDACTED] - We have recently switched to using the Transgender Congruence Scale, which has been validated and can be tracked over time to observe whether congruence is improving/dysphoria is decreasing. It is inclusive of all gender identities. Huit, T.Z., Ralston, A.L., Haws, J.K. et al. Psychometric Evaluation of the Transgender Congruence Scale. Sex Res Soc Policy (2021). <https://doi.org/10.1007/s13178-021-00659-7> (https://doi.org/10.1007/s13178-021-00659-7)  
 In clinical practice, we are only doing this at our initial intake at this time, and truthfully generally find the provider history-taking to be th...

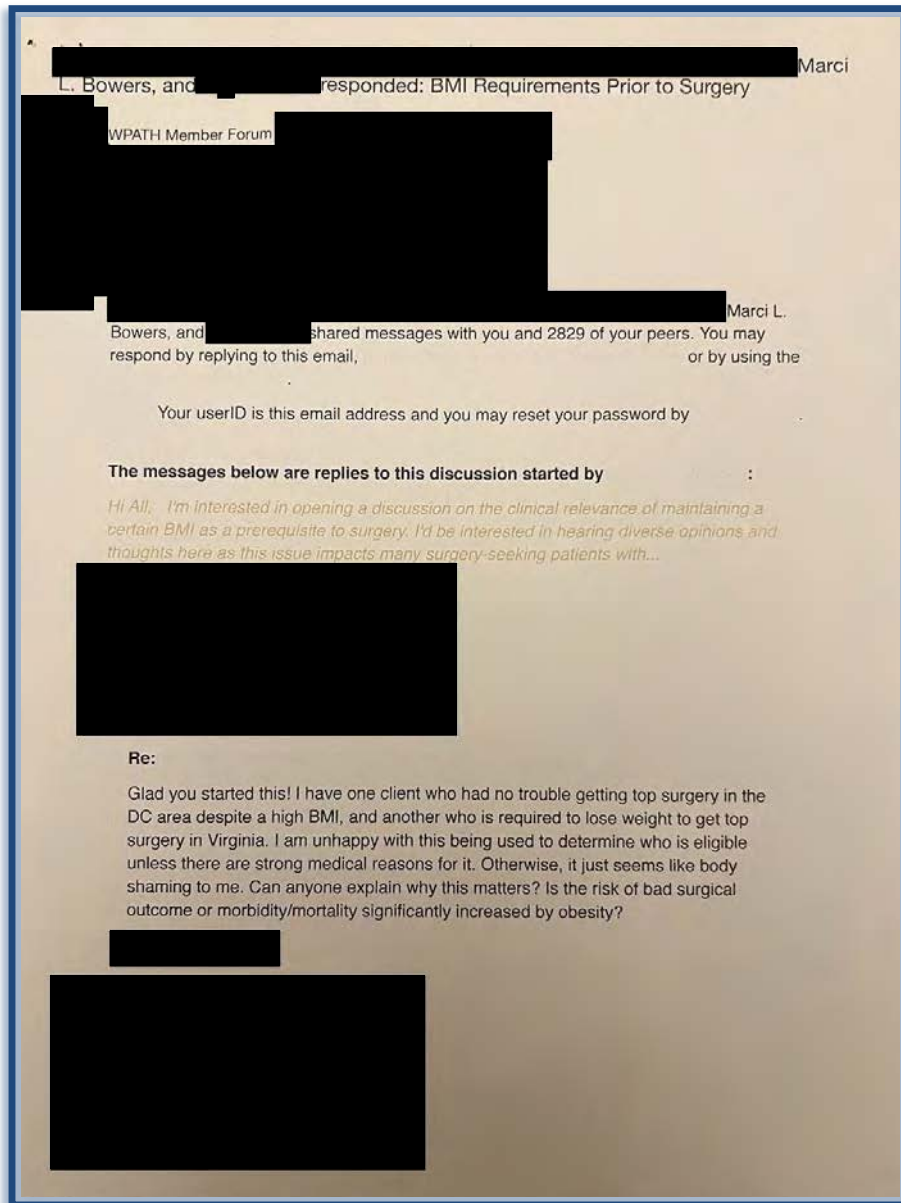


*b) A WPATH member expresses a lack of validated measures to determine gender dysphoria severity*



19) BMI REQUIREMENTS PRIOR TO SURGERY

a) *WPATH members discuss the clinical relevance of maintaining a certain BMI as a prerequisite to surgery*



Re:

Thank you for introducing this topic here. I have had several clients who have needed to delay surgery (one who did manage to lower their BMI) and at least one who may not have access to surgery at all given BMI requirements. It's disheartening and my understanding of the reasoning behind the limits has not squelched my concern for heavier people who need access to surgery and are not likely to healthily or successfully get their BMI in range. I look forward to this conversation.

[REDACTED]

[REDACTED]

Re:

It goes to outcome. Poor outcomes are noted in significant numbers of pts with elevated BMI especially if diabetic or with other comorbidities. Trust me, poor surgical outcome is far worse than any dysphoria from not being able to proceed with a particular surgical procedure.

[REDACTED]

[REDACTED]

Re:

I have a client seeking top surgery, and following a discussion about his eating disorder, was told to lose weight. This triggered disordered eating, and we have been working to get his eating disorder under better control since.

I have another client who was told he needs to be admitted to the hospital for top surgery due to his BMI. His insurance does not cover this, and he cannot afford the astronomical cost.

I am extremely interested in this discussion. I have been thinking of approaching a surgeon who does not have a BMI limit [REDACTED] to ask if conversations, doc to doc, could be had. I am in Washington state.

Thank you.

**Re:**

My understanding for the BMI requirements is that they are clinically relevant to decrease the likelihood of post operative complications. A high (or low) BMI increases the risk for poor post surgical outcomes for ANY surgery, not just gender-affirming surgeries.



Transgender Surgery, Obstetrics and Gynecology  
Dr. Marci L Bowers, MD

**Re:**

High BMI (greater than 40) is associated with lesser outcomes, longer operative times. But we truly do try not to fat shame patients. That said, weight loss is a great thing with surgery as a carrot towards better health and surgical outcomes. I'd truly pressed, we can make it work out safely.

- Marci L. Bowers

**Re:**

The recommendations for BMI thresholds for gender affirming surgery are mostly extrapolated from other similar procedures, though overall there is little quality data regarding surgeries on patients at higher BMIs regardless of the surgery (trans or not),



• • due to systemic fatphobia and lack of quality care for people who are at higher BMIs. Poor health and disease is blamed on high BMI, people are told to lose weight before surgery, etc., and thus nothing is done to actually treat people at higher BMIs because the first go-to solution is to ask people to lose weight before doing anything else.

I think a great next-step toward a solution would be for surgeons who are doing surgeries on patients at higher BMIs to publish their data about the outcomes. Additionally it would be great for providers to be educated on the low success rates of sustainable weight loss and take that into account when prescribing it to patients prior to surgery, and instead try to figure out other alternatives to allow patients to have surgery safely. I don't dispute the fact that outcomes are riskier at higher BMIs, but I do dispute that it is the fault of adiiposity itself rather than weight bias influencing how patients at higher BMIs are cared for and operated on.

[REDACTED]

[REDACTED]

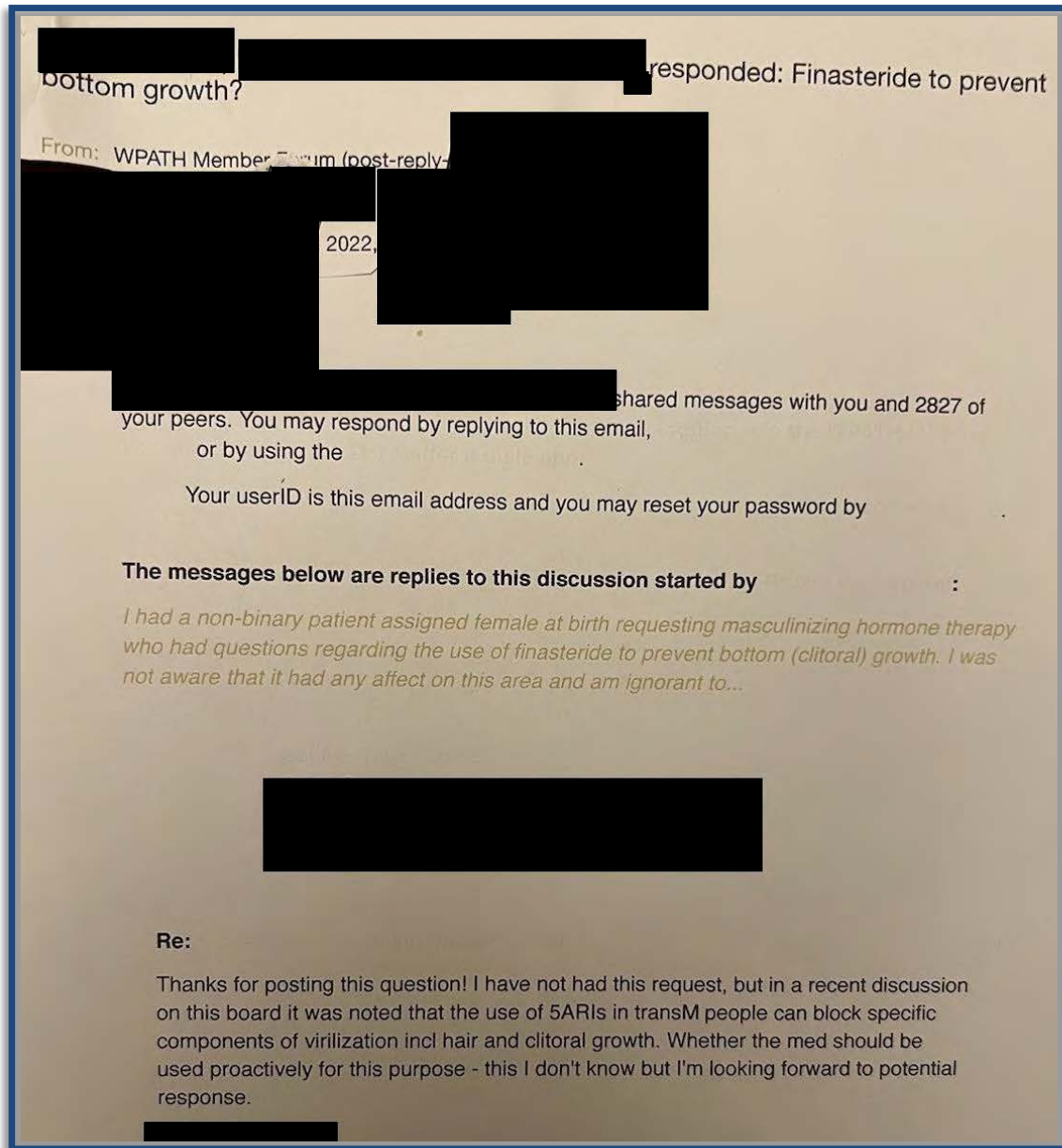
**Re:**

I do want to add on, I recognize that this is a systemic issue and not the fault of any individual provider. I think most people are doing the best they can with the info they have to provide safe surgeries. However that doesn't also mean positive change can't take place to allow patients at every size to have surgery safely and to learn more about how best to support patients at higher body weights without defaulting to weight loss as a first option. Like you mentioned it is also important to take into account the high prevalence of eating disorders in trans individuals and that recommending weight loss to access surgery can exacerbate this.

[REDACTED]

20) HORMONE COMPLICATIONS

a) WPATH members discuss the use of Finasteride to prevent bottom (clitoral) growth



**Re:**

I haven't had experience with this use of finasteride or this request in particular, but my understanding is that finasteride blocks the conversion of testosterone to dihydrotestosterone (DHT). DHT is primarily a hormone important for embryological development and in the adult cis-male is active in scalp hair follicles and prostate tissue primarily. I would guess that clitoral growth would occur to some extent in response to testosterone even in the presence of finasteride, but will be interested to hear if others have tried using it to block clitoral growth.

[REDACTED]

[REDACTED]

**Re:**

I have had a similar patient who is requesting finasteride to prevent bottom growth whilst starting testosterone.

We have not been able to find any evidence for this but it is clearly something that is being discussed in the community.

It has been difficult to give them a definitive answer. Any resources, evidence or advice would be appreciated.

21) ETHICAL GUIDELINES TO ADOLESCENT CARE

a) *WPATH* members discuss the Standards of Care (SOC) ethics for treating a developmentally delayed, 13-year-old

DISCUSSION

**Ethical inquiry - adolescent**

Pediatric Transgender Medicine (293 members), Transgender Healthcare Policy and Public Health (1093 members), Transgender Mental Health (1731 members)

3,198 Discussion Views  
5 Responses

In a developmentally delayed 13yo adolescent, currently on pubertal suppression, that may not reach the emotional and cognitive developmental bar set by SOC\* within the typical adolescent time frame if at all, what is the ethical approach to care? When would gant be indicated?

\*6.12.c "the adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.

Many thanks,

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Hi [redacted]

How developmentally delayed is this young person and how was their cognitive capacity for consent measured and evaluated? What is the level of consent and cooperation from the parents or guardians? I have had a couple of youth ages 14 and 15 with PDD, both MtF, one of whom was considered able to consent and was affirmed and one of whom was not, according to the specialists. It apparently was based on their psychiatric stability. Because the SoC8 does not get this far into the weeds on young patients, I think the judgement is left up to individual teams, their expertise with developmental concerns, social...

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This is how I would approach this if asked to advise:  
A guiding principle would be weighing harm of acting vs not acting. If the adolescent's gender identity has continued unchanged and the pubertal suppression is preventing unwanted pubertal changes or suppressing effects, then continuing to suppress puberty remains important to prevent harm from stopping it. As you know, leuprolide cannot be continued indefinitely (past 1-2 years) without a sex steroid hormone as well, to prevent bone mineral and density loss. This risk ...

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The SOC's pretty clear that an interdisciplinary team approach may be preferable in some cases, or finding a way of communicating important ideas in a different way (perhaps involving the kid's parents or other providers, to get a better sense of what's worked in the past?), and that in others we're required to take the time to ensure folks understand the risks and benefits of treatment. Kids with intellectual disabilities are able to consent to other surgeries. I wonder if there's important context your question is missing? Or if you're looking for a particular kind of approach? But so much depends on the particular kid... Thanks for asking this! Excited to see if others offer...

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I think the key here is careful assessment by the entire team, and then careful collaboration. Are the parents completely supportive? Is there any reason to believe that the delays would be significant enough to alter the pathway of transition? I would look at having an evaluation by a child life specialist, as well as another provider.

I suspect there is no one perfect answer, but it certainly makes sense to have a consensus with the developing child. I would also make very certain of where the parents are with the assessments, desires of the child, and the available GAHT plan. If in doubt, do not harm....

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You may find the following paper helpful:  
<https://jme.bmj.com/content/49/2/110>  
(<https://jme.bmj.com/content/49/2/110>)

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# Transcript: Identity Evolution Workshop held on May 6, 2022

A different recording of a 1 minute and 30 second clip from the panel discussion (which is 1 hour and 22 minutes in total) was leaked into the public domain over a year ago. The video in the WPATH Files is a new recording, has a different layout, and has no connection to the previous leak. The time stamp of the previously released portion of the WPATH video is 23:16 - 24:43. This is the first time the panel discussion has been made publicly available in full.

## CLIP 1

**Cecile Ferrando:** Transmasculine patients. And we talk about, you know, early oophorectomy, so early removal of the ovaries and what that means in somebody who is taking testosterone therapy but may not be on testosterone their whole lives. And I simply sort of explain the need to have to supplement, you know, in order to have cardiovascular protection, bone health, good bone health as they get older.

Um, so those are the things that we think about in this cohort of 20 year olds in whom we're removing the ovaries. There's some concern that long term, if they ever stop their testosterone, they could be at, um, um, at metabolic risk, which is just something that needs to be considered. But historically, we have a patient population that also doesn't seek out medical care.

So there's that sort of confounding factor too, which makes it a little bit trickier. Um, but at the end of the day, it's about informed consent. And on my end, I'm just managing patients who have sought out treatment in alternative ways. Um, and that those are, those, those can be pretty challenging.

**Ren Massey:** Thanks, Cecile. Would anybody else like to add some observations?

**Dan Metzger:** I think, you know, when we, when we start people on, um, testosterone or estrogen, uh, you know, we, we try to be as clear as we can, um, about the stuff that's going to be permanent and the stuff that's, that's going to go backwards. So if you started testosterone, your voice is going to change. That's permanent, but you might get more muscly, but then that's not permanent if you were to stop.

Um, I think the thing you have to remember about kids is that we're often explaining these sorts of things to people who haven't even had biology in high school yet. And, and, um, uh, and I know I've, I've heard others in, in this kind of a, in this kind of a setting say, well, we think adults are like really slick biologically.

And in fact, lots of people have very little medical understanding of stuff like that. We just put medical professionals and. mental health professionals take for granted. So I think we have to be, um, more concrete than we think we need to be. Um, short of surgical stuff, you know, I think, I think, um, uh, and the permanent physical changes that happen with testosterone or estrogen, um, you know, you might get some breast development that maybe you would later regret.

Uh, but I think, um, it's reasonably safe to, to be on hormone X for a while and then stop and go back to your, to your natal hormones. Provided you haven't had some sort of a gonadectomy, then, as Cecile mentioned, that's a different issue if you're hormone less, um, so, um, I think that is important, um, for people to know, and I think we also, like, just in general, you know, people want this, but they don't want this, but they want this, but they don't want this from a hormone, and I'm like, well, you know, you might not be binary, but hormones are binary, and so, you know, you can't get a deeper voice without probably a bit of a beard.

It doesn't work that way, or you can't, um, you can't, uh, you know, get estrogen to feel more feminine without some breast development. It, that doesn't, that doesn't work very well. And there are different ways of trying to get around some of these things, but in general, um, you know, when you give a hormone, it's going to do what hormones do.

It's going to act on a receptor, the receptors are everywhere, and you're going to get some sort of a physiologic effect, and it's hard to kind of pick and choose the effects that you want. And, and I know that that's, um, I know that that's, uh, like something that kids wouldn't, wouldn't normally understand because they haven't had biology yet, but I think a lot of adults as well are hoping to be able to get X without getting Y,

and that's not always possible.

## CLIP 2

**Ren Massey:** Thanks, Dan. Yes, expectations and informed consent. We have a lot of work to do here, even as mental health professionals, um, in my work, I, even before having folks start on hormones, I go over a lengthy, um, information about the effects of the different kinds of hormone therapies, uh, just so they, I have the clarity that they have some sense of understanding what they're going to because even the good hormone docs here in my area.

Don't always take the time, or it's easy for us to make assumptions that people understand. You know, but that estrogen is not going to make somebody's voice go higher. Or if you're a certain age, testosterone is not going to make you taller. So, um, manage expectations, I think is really important. Uh, it looks like Dianne's ready to say something.

**Dianne Berg:** Yeah, I just wanted to piggyback on all of the importance that comes up with the informed consent. Um,

I often see people who, because there's such a backlog of therapists to do some of the mental health therapeutic support, I often see people who have already engaged in some sort of, and this is again with youth, who've already engaged in some sort of medical, um, intervention. And so one of the things I do is I just kind of I'm sitting with the youth and their parents and I say, Oh, well, so tell me more about what you know about that medical intervention.

And kind of like what Dan was saying, you know, children and young adolescents, we wouldn't really expect them. It's kind of a developmental it's out of their developmental range sometimes to understand the extent to which some of these medical interventions are impacting them. And so I think I, I try to kind of do whatever I can to help them understand best, best I can.

But what really disturbs me is when the parents can't tell me what they need to know about a medical intervention that apparently they signed off for. And so I think informed consent has to happen very differently for parents. That it has to happen for



children and early adolescents and adolescents, but it needs to happen and it needs to be a process and, and I think therapists are in a really good position to do that process because we have a lot more time.

with our people than like the 20 to 20 minute medical appointment the way that and that's another problem is the way the medical system works is is there's often very little time. So I think it's really one of our roles is to really do that and to really suss that out and take quite a bit of time to do that and it's more than just like we certainly provide information but then you kind of have to listen to what the the youth is doing with that information to to kind of not, not catch them, but to pick up on the ways that they're not really understanding what, because they'll say they understand, but then they'll say something else that makes you think, Oh, they didn't really understand that they, that they are going to have facial hair, right?

Because they say something else that makes you think, Oh, they didn't get that point, but they'll say they totally get it.

### CLIP 3

**Dianne Berg:** This comment on is that I worked in a, um, an intersex or disorders of sex development clinic for a number of years as the psychologist. And I would come in to the session with the parents and usually these were very young kids. So I wasn't really working with the kids. I was more working with the parents and, and I would come in there after the, after the medical doctor had, after the pediatric endocrinologist had been in there and done, had been in there for an hour and had talked with them.

Um, and. The pediatric endocrinologist came out and said, yeah, they totally get it on board. I don't have any concerns about their understanding. I would go in and I would say, okay, so tell me what you learned from, and they'd just be like, 'We have no idea what they were talking about.' Because they, they feel deferential.

Part of it is that they feel less deferential to the kind of doctor I am than the kind of doctor, the medical doctor is. And so, and because they really are seeking the care, they're just gonna. Say they know when they really, they really aren't picking up on what's happening. And so I think the more we can normalize that it is okay to not get this right away.

It is okay to have questions is, you know, the more we're going to actually do a real informed consent process. Then what I think has been currently happening and that I think is frankly, not what we need to be doing ethically.

**Ren Massey:** Thanks, Dianne. I appreciate those comments. Um, anything you want to add in there, Gaya?

**Gaya Chelvakumar:** I would just say I agree with all the comments that have been made. I think the informed consent process is so important and definitely that it's a process is really important to recognize that it's not one conversation at one point in time that is many conversations over time, um, and that those conversations don't have to stop once the Medicaid and intervention has been started, that those conversations can be ongoing even after the intervention has occurred.

Um, even asking how they feel about changes that are happening and, and having discussions about is this something you want to continue with to not, um, you know, informed consent is such an important piece of starting any intervention and it's so, it's so hard. And I often wonder about what you mentioned, Dianne, about people saying they understand when they don't, just because they're so focused on the intervention that, um, They're afraid to share things that they might not be understanding about the information we're sharing with them and how, how to address that I think is very, is very important.

I will say just personally my practice, it has evolved, how in the medical setting. I think we have these Conversations and, um, around informed consent has evolved a lot over time as well, just recognizing a couple of different things, you know, that identities may shift and transition needs may shift, um, that also has shifted how we have, I think, conversations around, um, around informed consent and starting an intervention.

But it's so important and just that it's a process and it's a continual conversation, I think, is the biggest thing.

## CLIP 4

**Dianne Berg:** And Gaia, I don't know if other people do, but I really struggle with, with, because I kind of want The kids that I work with, whether they're nine to, you know, 13

and looking at puberty suppression or hormones in some ways to be a little pediatric endocrinologist, like I, I want them to understand it at that level, um, in an age appropriate way.

And I struggle with that on one level because it's like, well, when a kid takes diabetic medication, do they have to understand? everything about their pancreas and everything that's happening and all of all of that do we do we do that same process around other medical kinds of things and so is this an unfair So, I just struggle with that line, um, and I just kind of wanted to, to say that because I'm not quite sure what to do about that.

The other thing that, that I, that I really like to do is I like to have the children or the young adult or the young adolescent or the adolescent come up with questions that they have for their medical doctor. So let's, let's, let's write a great question. Write that down. Write that down. We're going to ask that you ask that the next time you come back so that they're, they're really, I think, um, one of the things we have in one of the papers that we published is how important it is to instill a level of autonomy into Okay.

Children and adolescents about their medical care and transgender people about their medical care that they get to be assertive. They get to ask questions. They get to be really well informed. And so we want to start that very young by having children like, ask a question, write down what you think and ask the doctor.

You can ask the doctor. Well, I can't really. Yes, you can. Yes, you can. You get to ask the doctor anything that you want to ask them. Um, and so really instilling that way of thinking about medical care, I think is important.

## CLIP 5

**Gaya Chelvakumar:** Important point two is just collaboration between the medical team and the mental health care providers so that there can be also ongoing discussions between team members. So if, when mental health providers are having conversations around expectations around Medicaid, it's just like, Hey, you may want to spend a little more time talking about this, or this is an area that the, there seems to be some confusion about, or parents or child are really, um, concerned about, I think.

In this, in this area of healthcare right now, multidisciplinary care is so important and being able to collaborate with each other is so, is so important and so helpful, um, because sometimes we're not, you know, maybe in the context of a medical appointment, the conversations that need to happen can't happen and then maybe there needs to be further conversations with, with a mental health provider to help make sure parents and children have all the information they need to make the best decisions for themselves.

Yeah, I agree. It's so helpful to be on these on these panels just to hear where everyone's at because I think we all are struggling with how to do this and that in the best way without overburdening our patients and families as well.

**Jamison Green:** But our health care system doesn't If I may jump in here, our health care system doesn't encourage this.

I mean, if you have a clinic, like already, like a university setting where Dianne is, or where Cecile is even, and I'm not sure where you are exactly, Dan, but I know many people providing this care are independent practitioners, and they're referring their clients to surgeons. Uh, across the country and their endocrinologist might be their actual May, they may not never, they may never have a, an endocrinologist.

They may be able to get their hormones prescribed through their primary care provider who doesn't really know necessarily everything about Transcare. They're basically trying to be supportive and you know, our health care system. It leaves us in the lurch all the time. And so to create, I agree that we don't necessarily need to be able to have If you have a known condition, like diabetes, you don't have to understand every nuance about what the insulin is going to do to you in order to give informed consent.

You need, but, because there's so much experience with that. But in this field, this is all new, this is all contentious, and that's where we run into problems. because everyone's afraid. And I know for a fact, people, even adults, even well educated, older adults, accessing care for the first time, sit down with the person who's going to prescribe their hormones, and they look at an informed consent form that says your hormones are going to do this, this, and this. They don't take any of that in yet because they're so scared that they're not going to get what they need. They, they just so, show me where to sign. Cause I'm, this is my moment, I gotta grab it. And they don't really take in the information.



## CLIP 6

**Jamison Green:** And people also are afraid many times about surgery and so they can read other people's descriptions about surgery and they'll miss details or they'll miss the, the, uh, the most important piece of information for them simply because they're afraid to read it. You know, it's just how human beings work.

So I think at the same time we're fighting against The community's desire to have less gatekeeping, less professional intrusion, less spending time in doctor's offices. And how do we manage that and make sure that everybody's got the right level of education to make good decisions for themselves? So this is a problem that we're facing.

And this is where I think some of the detransition comes in. Because the over medicalization, as well as Uh, over binarying, as well as just the pressures that people are under because of the opposition creates a dynamic that's very, very hard for all of us to work in. Trans people and clinicians, very, very hard.

So I think these dialogues are crucial and we need to take them outside of this space ultimately as well.

**Ren Massey:** All right. So I'm, I'm sorry. Did you want to go ahead?

**Dan Metzger:** Good. We can do it after the.

**Ren Massey:** Yeah, I was going to suggest you this great conversation. I have more comments, but I'm like, ah, people probably need a break attendees as well as panelists. So, uh, I've asked for a 12 minute break. And we will reconvene back here and look forward to seeing y'all back here in a little bit. Thanks.

## CLIP 7

**Ren Massey:** I think we're pretty close to on time for that 12 minutes. Appreciate everybody being back here. Um, I'm wondering if, uh, well, I wanted to share just a little bit about informed consent. And then after, if anybody else wants to chime in, feel

free to. I saw a little bit going on there. I do think that that's a really important part of what we can do to help folks.

Um, in terms of their decision making processes and also, you know, just to start out with, I make it clear to people that I don't have an investment, whether they're youth, whether it's parents. Whether it's adults that I have no investment in what their gender identity is even just because transitioning was right for me doesn't mean that it's right for somebody else.

And that's not a bias that I have. And, um, I hope that that gives people from the start a sense of safety in, um, considering a range of options in, um, in terms of gender identity and gender expression possibilities. Uh, when we do get to talking about, um, hormonal and medical interventions for those who, uh, are considering those options. You know, one important thing I believe is to make sure we address fertility preservation. If you all have looked at the drafts of the standards of care coming out, S. O. C. Eight. Hopefully next month, you'll see, you know, a number of places where it's encouraged and ethical to talk about fertility preservation options And that's even for youth who are going on puberty blockers, because many of those youth Thank you for nodding heads. Many of those youth will go directly on to affirming hormone therapies, which may eliminate Or will eliminate, you know the development of you know, they're gonads producing sperm or eggs that are going to be able to be usable if they want to be partners with somebody else later in contributing genetic material for reproduction

## CLIP 8

**Ren Massey:** I start even with puberty blockers to talk about fertility and a useful tool has been John Strang's TYFAQ, the Trans Youth Fertility Attitudes Questionnaire. It's not necessarily standardized to my knowledge, but it's a mechanism for discussing. There's a parent version and a child, a youth version for discussing some fertility issues just over, I think it's 16 questions.

And then also my informed consent process, I will include, um, as a non medical person, but somebody in the healthcare profession with a lot of. experience and knowledge and G. E. I. S. Under my belt attend all these conferences. Always learn something. I cover the reversible and irreversible effects and the potential risks to the best of my again.

I'm a lay person as far as being not a medical provider. Um, knowledge and I base that on the standards of care seven and we're gonna have the new ones coming out as I mentioned as well as the interim guidelines. Uh, the latest being in 2017. And there are some other resources out there. So, um, I see somebody put a file up there but there are ways I think we can all go over this.

And also just finally, I'll just add that I go over it with the youth separately from the parents. Uh, and then with the parents separately from the youth, ideally, and then bring them all together. Make sure we're all on the same page of under what we understand. Um, Limitations acknowledged, and, uh, you know, they're often having questions, and I say you have to ask your hormone provider, the consultant you're, uh, going to be meeting with about, uh, certain questions.

So there are certainly, I stay within my lane, but I do think that part of the multidisciplinary nature of this work is being well versed in these things, at least to a certain level, and that's part of why we have a multidisciplinary panel here.

## CLIP 9

**Ren Massey:** wants to, I see somebody added the QIFAQ in there. Anybody wants to add any comments on that before we move on and we could potentially start looking at cases in a little bit? Does anybody want to add anything to what I said? Looks like Dan might.

**Dan Metzger:** I, I was just gonna say, you know, like, like it's always a good theory that you talk about fertility preservation with a 14 year old, but I know I'm talking to a blank wall. And the same would happen for a cisgender kid, right? They'd be like, Ew, kids, babies, gross. Or, or the usual SPAC answer is I'm going to adopt. I'm just going to adopt. And then you ask them, well, what does that involve? Like, how much does it cost? Oh, I thought you just like went to the orphanage and they gave you a baby.

No, it's not quite like that. Um, but, um, and I was just trying to find it, but I can't, I can't quickly locate it because I only have is like a picture of a slide, but apparently last week at the Pediatric Endocrine Society, uh, some of the Dutch researchers started, uh, gave some data about, um, young adults who had transitioned and reproductive regret, like regret, and it's there.

Um, and I don't think any of that surprises us. I don't remember any of the numbers or anything. I just, again, I have a picture of a slide. But hopefully this is something that will get published in the next while. But, um, you know, I think, I think now that I follow a lot of kids into their mid twenties, I'm always like, Oh, the dog isn't doing it for you, right?

Yeah, they're like, no, I just found this, you know, wonderful partner and now we're kids and da da da. So I think, you know, it doesn't surprise me, but I don't know still what to do for the 14 year olds. The parents have it on their minds, but the 14 year olds, you just... It's like talking with diabetic complications with a 14 year old. They don't care. They're not going to die. They're, they're going to live forever. Right? So I think, I think when we're doing informed consent, I know that that's still a big lacuna of, of that we're just, we do it. We try to talk about it, but most of the kids are nowhere in any kind of a brain space to really, really, really talk about it in a serious way. I, that's always bothered me, but you know, we still want the kids to. Be happy, happier in the moment, right?

## CLIP 10

**Dianne Berg:** I appreciate that much less with a 9, 10 or 11 year old who's, who's, um, who's starting puberty suppression. And like Ren said, if they continue on then, and, and I mean, it's, it's like developmentally not in their space to be able to have, have to think about that. And it shouldn't be, um, right. And so I think it is.

I think it is a real growing edge in our field to kind of figure out how we can, how we can approach that. Um, I'm definitely a little stumped on it.

**Gaya Chelvakumar:** I'll just add one more complication in there is that then if you do have, which doesn't commonly happen, but if you are interested in preserving fertility, then the options for for doing that, depending on age and stage of development also can be. From a medical standpoint, may or may not be possible, but then from a financial standpoint, also may or may not be possible, and that's another complexity to the, adds another layer of complexity to these discussions as well, and that's at any age, I guess.



**Dianne Berg:** And from a social and sexual standpoint, right? Um, in some ways, the stuff that you need to do to be able to preserve your fertility might be beyond kind of what a youth, where a youth is at in terms of their sexual development, and yet.

That's kind of what's needing to happen and, um, yeah,

**Ren Massey:** yeah, I don't think that we have all the answers and I appreciate y'all's comments, bringing, you know, highlighting the nuances and the challenges here. I find a range of. Maturity levels and having thought about this or not having thought about it. Um, again, depending also on the age and the cognitive maturity, emotional maturity.

Um, I still, I know you all do these kinds of things too. I think that it's better to give them the information and have them, Be able to reconcile, like we wish we could afford this, but at this point we can't. And so we will proceed down this avenue anyway, but not later on then find out, Oh, nobody ever told me that I couldn't, you know, do that.

## CLIP 11

**Ren Massey:** Like, why didn't somebody tell us? And so I think that there's a shift in the field, but I just think we need the spotlight that, um, it's part of the discussion in the informed consent process for youth as well as adults. Um, And back to the thing I said the very beginning of after the break, part of also trying to make sure people have a sense of I have no investment in where their gender identity or identities land is because that part in this study where people said they didn't go back to the same provider, that that bothers me, I would like people to feel like they can continue with me whoever they are.

Um, if I can help in other issues, you know, a few of the folks I've worked with, it's been, um, some of what Dianne was saying earlier, you know, their sexuality got to clarify some of their gender identity issues. And, um, they, I've been pleased when they've gotten clear. Okay. Maybe I'm not trans, maybe I'm non binary, maybe I'm cis, um, and maybe this was more of a sexuality issue.

And they were willing to continue to work with me as they explored sexuality issues. You know, I want people to feel like they don't have to perform a certain gender to be

working with me. Um, that I want to be inclusive and supportive of all aspects of their being, so. All right.

## CLIP 12

**Ren Massey:** Any other thoughts before we maybe look at cases? Alright, as, as we shift to cases, then, uh, this is always the tricky part for me to work on.

**Dianne Berg:** I'm sorry, Ren, can we just, Melissa Goldstein is just asking if anyone has great resources for fertility and preservation especially. Oh, Gaia just put it, did you just put it in?

**Gaya Chelvakumar:** I just popped in one article that starts to discuss some of it.

**Ren Massey:** I'm, I'm glad. I think, I think that that's a knowledge, right? And there isn't a ton of, of that existing. So I just wanted to acknowledge that. Yeah. All right. Thank you. Um, it's wonderful how we've got all these wonderful resources here. All right. So, uh, bear with me a second. I am going to try to share screen to, uh, go over some cases that our panelists have, uh, put together.

And this is the part where I always grapple.

## CLIP 13

**Ren Massey:** Read the case of DJ. Give me a thumbs up, panelists.

Okay. All right. So I'm wondering if panelists have any comments or thoughts you all want to start with in getting this discussion going around this young person and their experience.

Oh, sorry, Randall. I'll read the next one.

**Dan Metzger:** To me, this is a not an untypical story. I mean, this person's got some significant mental health stuff, which is, you know, that they need to deal with. It

sounds like they had an unfortunate sexual traumatic sexual event, which that sounds probably pretty horrible. But to me, this is a kid who, who, who. Um, got a false start and, uh, and, um, maybe it wasn't in a place where they were fully supported or they feel fully supported.

Um, but to me, this is not de transitioning. This is just a kid working through crap. And, um, I mean, I obviously may feel sorry for the kid, but to me, this is not like something that should hit the news as a, you know, a system problem. You know, assuming that this kid's been getting the mental health care that they need.

To me, this is like, not an untypical story. Um, and with a happy ending. So, yay.

## CLIP 14

**Dianne Berg:** highlights the importance of having ongoing support and following kids over time, um, so that you're getting as much of the picture as you possibly can. And, and so kind of the important role of, of behavioral health, mental health, um, component. Um, I think, I think oftentimes mental health can get a really bad rap.

Um, in terms of that, we're trying to do things that we're not actually trying to do and, and so I think this is a good case that kind of exemplifies if you're following this kid and meeting relatively recently, relatively, um, often with them, you're going to kind of be seeing this in real time and be going through this with them and be helping them to process and figure out kind of the meaning that it has for them.

Um, And hopefully as you have enough of a rapport, I don't know if it happened in this case, but that it looks like the, the person didn't disclose some of the bullying and the traumatic sexual event until a year later. The hope would be that if we can build enough rapport over time with kids in whatever specialty we have.

That, that we would learn about that in more real time than a year later, and that we would be able to be, you know, kind of just doing it as part of the regular process of checking in about all spheres of life. Um, so it really highlights the importance of that for certain, for certain youth.

## CLIP 15

**Ren Massey:** comment. I noticed an observation or a wish that, uh, therapists involved in able to Help the young person distinguish between the assault and their gender identity. I think, um, that there are times working with young people where they don't even disclose an assault or some type of sexually, Coercive or unpleasant experience.

It may not even have been coercive, but it may be almost like self coerced. They thought they were supposed to do X, and so they, like, I guess this is how people interact sexually, and so they showed up voluntarily, like this other person at

the moment, um, wasn't coercing them, but they were kind of trying to get themselves to learn about sex. And so they may have done things they didn't even feel comfortable with. And so they don't want to talk about it with therapists. So, I mean, um Even good therapists, you know, we're going to be limited at times where we're, uh, we can't get everything that's going on with our kids that we're working with.

And sometimes the adults also don't bring it forward. So, um, it's a, it's a high bar to cross sometimes to try to catch everything that. may be affecting somebody's view of themselves and across domains of their life experiences.

## CLIP 16

**Gaya Chelvakumar:** And I'll just echo Brennan and Dianne's statement. I think the case to me just highlights the need for, in addition to continued, you know, ongoing care, but also maybe like leaving the door open, that if this is your decision at this point in time, but that may change and we're, you know, we're here to support you, whatever your decision is, and that you can always, you know, continue to see us continue to see the team, um, you know, keeping, keeping engaged with young people and letting them know that they can, It's okay to change your mind.

It's okay to, to come back and knowing that, um, people sometimes have to disclose things in their own time as well. So that while we hope things are disclosed in real time, sometimes people just aren't in a place to face, to face their trauma and what's going on. And so even more so becomes important, I think, to have that ongoing care.



Um, and even if there is an ongoing care, at least leaving the door open, young people, or adults even, are in a place where they want, where they want to reengage that that door is still open?

**Dianne Berg:** Yeah, there, there was a comment. There was a comment in the chat about, um, sometimes our, our discomfort with asking questions, particularly pertaining to sexuality.

And I, and I think that that's, that's really true. I mean, we have not gotten to the place yet where it's just part of, Every typical kind of area that you inquire about, and I think that that's really important, um, and is, is part of, and, and to not, and to not frame sexuality, I think the other thing that happens with sexuality is it gets framed as negative, all the things that we shouldn't be doing, um, rather than having a positive, kind of positive take on sexuality, and so how with, with youth and, are adults.

Do we just naturally feed that into the conversation? And how do we as clinicians get comfortable with sexuality and sexuality themes? Um, in a society that isn't very comfortable with it, but isn't comfortable with it in appropriate ways is very comfortable with it in some ways that probably aren't very healthy.

And so how do we teach people to do that? I think that's one of the benefits that That I have working in a sexual health kind of clinic that has a gender component to it. And I think that's really important.

## CLIP 17

**Ren Massey:** All right, thanks. Going, going, gone. Move on to our next case. Okay, if I can get my screen share to cooperate with me. Ah, here we go. All right. Cases. This is a collective consideration. Several trans men in their late 20s, early 30s have done a range of social and medical interventions. They're now clear that in hindsight, if they had come out ten years later, they may not have taken all the medical transition steps that they did if the option of a non binary identity had been on the table. They don't like to be seen by others as male, but given the physical changes, don't feel like they have a choice. There are different intensities of how upsetting this is to them, but a common theme is not likened to be perceived as male by others to the extent they are seen as male. I found this really interesting.

Who would like to jump into this conversation?

**Dan Metzger:** This is a bit beyond my age group, but I think one thing that they could do, uh, medically is to talk with their hormone provider to see if there's a way. I'm presuming these people are still on testosterone, if they are, that they could at least lower the dose to something that's still bone protective and still would make them feel okay, but maybe wouldn't, uh, would less stimulate, uh, you like facial hair growth or or the other kinds of things.

I mean, their voice is not going to change, obviously, but, uh, there might be some room to play with the testosterone dosage just to make things a little bit less, uh, um, less masculine.

## CLIP 18

**Cecile Ferrando:** Um, so I think this is about goal setting. Um, so you know, while I'm a surgeon, I do a lot of testosterone implants for patients. So I do testopel implants. Um, and, um, when I talk to a lot of patients, the majority of the patients I see, they are seeking, um, realization, masculinization. So I dose them to sort of physiologic levels.

Um, but I have sort of this, um, cohort of patients that is seeking sort of, you know, underdosing, but wants testosterone, um, supplementation. Um, so we sit and we talk about. The goals of therapy, understanding whether, you know, I have to explain to them that sometimes underdosing can, um, will not lead to cessation of menses, which is sometimes the actual goal, like not virilization, but cessation of menses.

And so, in those situations, we talk about, you know, what other things we can do that, um, that may not have sort of either feminizing effects, you know, a lot of our, Transmasculine patients don't want to be on oral contraceptive pills, etc. So sometimes I'll underdose testosterone in a pellet form. Um, and also, um, place an IUD in those patients.

And so it's really sort of about discussing what their goals are. I'm now seeing younger patients. So not necessarily patients who were dosed on, on doses of testosterone and who are now working backwards. But I have a couple of patients in their twenties who.

Sort of err on the side of the masculine side on the spectrum, but don't want to be fully masculinized.

So I'll underdose them as well. And, you know, I think that there's a physiologic component to this improving their, their sort of state of being and giving them a sense of wellbeing. But also I think that there's this component of, um, I feel like I'm taking some steps towards masculinization, but not completely.

So that makes me feel good. And I think that there's. Also, I think we, um, uh, actually to this crowd, I'm not gonna say undervalue. I think, um, uh, people in my, um, from where I'm coming from undervalue the importance of giving a patient a sense of control of their transition and their care plan, which is not a foreign concept when we talk about.

You know, paternalism and autonomy, but certainly when it comes to this type of care, allowing patients to have some control over what it how their transition is or what it is, is really important. So even in patients who've been on high dosing who want to work backwards, but like Dan just pointed out, sometimes you can't reverse everything.

Right. So there's some masculinization that will have already have occurred, but perhaps just the giving a patient the sense of being able to control what's going to happen down the road is really important.

## CLIP 19

**Cecile Ferrando:** testosterone dosing. For me it's easier in the pellet form because you can really sort of dose to certain levels. It's in my, from my experience, easier to control than intramuscular and subcutaneous dosing. But it's about goal setting and discussing and so much can just come from a discussion of I understand that what your goals are and let me see if I can help you achieve them.

Certainly that conversation is easier when it comes to hormones than it is surgery.

**Dianne Berg:** There are a little bit, I think what it comes up, what comes up for me is helping people to explore socioculturally what it means to be masculine, feminine, male, female, um, because there's kind of the internal sense of it and then there's also

the the way that that gets perceived in the world and It sounds like for some of, for some of these folks, like, for whatever reason, it's more about how they're being perceived by others and maybe, maybe kind of what others are then attributing to them or assuming about them because they're, they're interpreting them as male when maybe that's those things, those, those aspects of maleness are not what they, aspire to or what they want.

And so I think it's, it's, it's all about kind of that, that therapy around what does it mean in our culture to be kind of, what does gender, what does gender mean in our culture? And how is that going to play out for how you see yourself and how others see you? So it's kind of those deeper, those deeper conversations.

## CLIP 20

**Ren Massey:** I just want to add something here. I appreciate what you were just saying, Dianne. One of my adjustments with my transition was, um, losing, um, automatically being perceived as safe. by females who I was meeting for the first time. And, uh, it was a very strange experience to be walking in a parking lot, you know, following a woman out in the parking lot from the grocery store, and to realize, oh, she's looking over her shoulder to, like, see, am I following her?

Am I a threat? Or to be in an elevator and... have, you know, somebody kind of scoot just about as far away as they can. And, um, it, it was, it was, it was a loss, candidly, not to be, uh, perceived or assumed to be safe anymore. Um, so I can easily see that some of these things would be, um, really distressing, um, social impacts of, um.

Being perceived as masculine in our culture. So, looks like you wanted to say something there.

## CLIP 21

**Dianne Berg:** Around kind of the other way too, right? I mean, so many of my trans feminine adult and even adolescent clients, um, Talk a lot about They they they hear



about it theoretically, but it's not until it happens that they really get it like not being paid Not being given as much airtime as they Become perceived as a woman.

Um, you know kind of all the the things that feminists have been saying for a really long time, I think, start to become more clear to people. And, and I think those are some losses or just some, some realizations around how gender plays out in, in sociocultural spaces. And And kind of what is that going to mean and how does how what meaning does that have for people.

So I think it, I think it goes both ways because gender is such a powerful mediator, whether we like it or not, it's such a powerful mediator of sociocultural spaces and interactions and environment.

**Ren Massey:** Yeah, I'm going to add to that, you know. A lot of us are youth or focused or heavy in our practices. Um, or young adults and, and minors.

Um, but One of my mentees, who I think is on this, um, meeting today and some other folks have talked to me about, you know, and I've even had clients as well who were adults who were assigned male at birth and found the loss of privilege and safety that they experienced in the world, um, was really disturbing.

And particularly some of the older folks. Um, we're actually, um, de transitioning, re transitioning for, for reasons of fitting in not just either around job stuff, but sometimes to be able to go into assisted care facilities with less hassle. And a greater sense of safety. So I think there are other issues, again, outside pressure sometimes, it may not even be the internal experience, that we need to be able to be aware of supporting people for in different contexts that we may be encountering.

## CLIP 22

**Ren Massey:** So um, yeah, one of the thing I would like to highlight on this case, I think that it underscores that from the in the outset, we also may help people explore more non binary options. You know, I have a young person I'm working with right now, um, who's been on blockers for about two years. Mother's anxious for the kid to come off.

Pediatric endocrinologist is saying maybe go a little longer. Um, and the kid is vacillating. Um, really not wanting facial hair. Um, but... about having menstrual cycles and kind of vacillates about whether breast development, chest development bothers them or not, and which pronouns they use. And we all know that chest surgery is pretty inevitable, or at least it looks like that, because that has consistently been a bothersome thing.

So, is there more, um, benefit of staying on blockers or letting the kid... switch back to their endogenous estrogen? Or is it better to go low dose testosterone or what? You know, and at what point in time? So, um, if the kid doesn't want facial hair, but maybe doesn't mind their chest growing and they're planning on having chest surgery anyways.

So we may want to, you know, be creative in how we help folks approach these. Situations that are complex.

## CLIP 23

**Ren Massey:** All right. So, um, I'm going to shift to the next one. I see we got a few other comments on, yeah, what people wanting. And being perceived male can happen very fast. Yes. All right. Let me try to get my screen to cooperate again. Okay. I'm going to read case three in S. 14 years, 11 months, assigned male at birth who identified as female preferred by previous mental health provider for gender dysphoria in the past year.

No significant medical history. Gender history and initial presentation, patient reported that a year prior to presentation a friend came out as bisexual and patient reports it clicked. Hey, that's what I'm feeling. Did not initially share this with anyone, but then six months later told mom about being bisexual.

Felt this confused mom. Around the same time, patient also reported feeling, looking pretty, cute and pretty. wearing female clothing. Reports always having felt this way, but never acted on the impulse to express self using feminine clothing. Patient reports that one month after school started, came to the conclusion they were trans.

Patient disclosed to an online friend first then told girlfriend who encouraged patient to tell mother. When patient told mom about identifying as transgender reports that mom's reaction was unsurprised. Patient had been trying out different names and eventually chose the name Nora. Patient reported feeling dysphoric and that sadness goes hand in hand with dysphoria.

Patient reported interest in starting gender affirming hormones but felt the gender affirming surgery was scary. Felt that mother was supportive of starting hormones, but father was not, and this could be a barrier. Extensive mental health history, starting at age 4, including aggression, ADHD, oppositionality, depression, anxiety, and challenges with behavior.

hospitalizations.

At 15 years, 10 months, the family is open to the patient starting spironolactone, but not ready to provide consent for estrogen. The patient's excited to start medication. Patient continued to follow the mental health provider two or three month intervals. At six month follow up after starting spironolactone, patient started, uh, reported that they felt more male and was feeling comfortable with he him pronouns.

Reported that I felt like a boy who wants to, I feel like a boy who wants to wear nail polish. Patient wanted to stop spironolactone and not interested in pursuing estrogen at this time. Plan for patient to continue to follow the mental health provider. Has follow up appointment in two weeks.

## CLIP 24

**Ren Massey:** Anybody want to jump in here?

**Dan Metzger:** I, I'm, so again, another kind of happy ending. Kids happy. Um, parents are happy. I, I, I think it's important to remember that not all kids are as smart as every other kid or as in tune with their bodies or minds or minds of kids.

## CLIP 25

**Dan Metzger:** sophisticated as other kids. Some kids like just get things and some kids don't and it takes a little bit longer. And the point is just because you're 15 doesn't mean you know everything. And I, I, I mean, I talk to this all the time, right? You're 15. That's great. But, um, you're probably going to know more than when you're 16.

You actually better know more when you're 16 than when you're 15. So I think it is kind of important to get, uh, uh, And this is our, you know, what our, what our assessors do is to get a level of sort of capacity of not just able to consent for stuff, but like they're understanding where they are. And do they understand that there's a difference between sexuality and gender and being trans and, and, and being, you know, cross dresser.

Um, that, that, that there's more than one way of. You know, liking nail polish. You don't have to be a girl to like nail polish. You can just be a boy and wear nail polish, whatever. So I think, you know, when these kinds of kids are working with their mental health professional, I think it is important for somebody to also really see, well, like, this is a kid that's kind of, not changed, but, you know, well, it's changed their direction three or four times within a short period of time.

That's not somebody you're going to want to rush in to do something permanent with. You're going to want to make sure that the kid, Really is starting to, you know, I have a clear direction of where they're heading before you do something and as well, you know, to make sure that the family are coming along with the kid.

## CLIP 26

**Gaya Chelvakumar:** I will also add that like an anti androgen like spironolactone is a nice place to start because it's something that probably is not going to give you, you know, irreversible changes. And so, you know, if needed to help kind of clarify needs and goals and identity, it's a nice, nice medication to use.

**Dan Metzger:** Yeah, I would second that, you know, like if this was a kid that was clearly binary and, and wanting to move forward, you know, then we would probably use Lupron because Lupron works better. It's way more expensive. But I think Lupron without a plan of moving towards estrogen for this kid would just make this kid feel crappy, probably because he's, she, sorry, is well through puberty.



Um, so she's probably just going to feel like whatever a teenage kid would feel when they have their testosterone taken away, kind of, you know, whatever, menopausal. So I, I think, um, Just to, just to, just to affirm, I think Spyro is a really good way to go because it's harmless. It's cheap. It works to, for the beard.

It's not going to prevent the bigger boy changes that happen with male puberty, but, um, it is a nice way to kind of ease into things and often, um, for families, for, for parents that are kind of holding back, it's a nice way to move forward. That's, you know, affordable, cheap, safe, and reversible.

**Dianne Berg:** I'm noticing a lot of stuff in the chat, but I think the medical people could maybe address that kind of comes from how fast testosterone maybe works and does low dose affect that can just noticing that.

**Dan Metzger:** Yeah, so it's true. I mean, we all, you know, Adult men all have the same testosterone levels, but there's clearly a different range of like how hairy you are or how fast you go bald or whatever.

And it doesn't have to do with your testosterone levels. It may have to do a bit with your testosterone receptors and a million other things that you inherit, um, in your genes. So, so, you know, I, I always kid the Persian, the Persian kids that come and see me, I'm like, don't even look at the bottle. You're going to get a beard.

Like, because we know it's going to happen really fast, and then some of the poor Asian kids, you know, they try forever, they could barely get a mustache going, like their brothers, and so, um, you know, but everybody's the same level, it's all the same dose, so, um, you, you, you do have to let people know that just because you're taking dose X is not, doesn't mean you're going to get results Y to, to, to the same extent.

And the same is true, of course, for, for, for, for girls taking estrogen, you know, breast

## CLIP 27

**Dan Metzger:** Level. Level provided your estrogen levels more or less in the nor in, in a, you know, in a normal range. It has much more to do with other genetic factors and body weight and stuff like that.

**Ren Massey:** Alright, great. So I think we have time maybe to go into one more case and um, then we may have some time for some concluding comments. Let's see. The biggest challenge is always there, the technology. Actually, the technology user is the biggest challenge. Okay, case four. An AMAB person assigned male at birth, who is now 13, who early on identified as binary trans girl and took all social transition steps.

Medically, the client is on Lupron and she's not been in a rush to start estrogen. However, she's been very invested in doing so at some point in the future. Within the last six months, this youth has begun to identify more as non binary, trying out different pronouns and names. She's very avoidant to have any discussions about What the shift toward non binary gender identity may or may not mean in terms of the decision she's always thought she would make in terms of medical transition.

When brooch will shut down and no longer engage. Have had some success processing when discussions are framed from an embodiment lens.

**Dianne Berg:** I can say a little bit about this case. I'm not sure whether it's one that I submitted and it just got kind of morphed and changed, um, which is totally fine. Um, but I think the thing that comes up for me, if it is kind of based on one of the cases is, um, But it was very difficult to, to kind of, um, the youth always kind of had it in their mind how their transition was going to work.

I'm going to do this. So I'm going to do this. So I'm going to do this. Then I'm going to do this. And, and it was all a very binary related kind of transition process and how they were thinking about it. And then as they, as they began to kind of try on. Different non binary identities and, and,

um, they started to kind of talk to people, uh, at least with the, with the, um, kid that I worked with.

## CLIP 28

**Dianne Berg:** Where we kind of got to was a general not wanting to talk about things because they were just kind of at that place. But also that they really thought that if they said anything about this and really delved into it, it would mean that their options

for any of that medical transition that they had always thought they were going to do would be off the table.

And so they were like, I can't, I don't want to explore that the non binary shift, because if I explore that, that means that I'm never going to be able to get estrogen or I'm never going to be able, and it was kind of like having some education around. No, it doesn't mean that what it means is we are trying to meet your embodiment goals.

And if your embodiment goals are such that you need a certain type of medical intervention, then you need that medical intervention and we can move forward with that. And you don't have to be afraid that, um, That your identity is going to drive necessarily drive your medical decision. It's more about your embodiment goals are going to are going to drive some of the medical decision making.

And so I don't know. That's kind of how we were able to get through that impasse. Um, So I don't know what other people kind of have to say about that. But, um, embodiment is certainly a concept that I'm using a lot more of with my adolescence and Children.

## CLIP 29

**Dan Metzger:** I, you know, like sort of 13 and a half is sort of our, like a kind of cut off where we, where we're okay to do hormones, if everything, it seems like it's going to work. Um, but I always told the kids, God, you're 13, you don't know everything. Um, I don't expect to know everything. And this is like a journey and you're going to take us, you know, we're coming along for the ride.

And, you know, we start this, it doesn't mean you have to continue. It doesn't mean you have to go up. every single time you come, I'm going to ask you what you want to do with your hormones. Are you happy where they are? And kids do shift with time. A lot of the, particularly the non binary kids, um, um, think that they want to be initially more vascularized than they end up wanting to be.

And they find that there's a happy dose that's gotten rid of their periods or whatever, and that they're happy on that dose. And they don't necessarily want to push forward

as they had thought that they might at the beginning. So. I think it's important that you just lay that out right at the beginning.

You do not, you do not have to have all the answers. You know, even an 18 year old, you do not have to have all the answers. Let's work with all we got today, and you keep letting me know, and I'm going to keep pestering you, you know, what do you want to do about this? What do about this? Or you're not ready to make any decisions, you don't even want to talk about it today.

Fine, let's just leave it in the same. And I think the kids need that space to, to know that A, they're in charge. Uh, B, I'm a little bit pushing them to think about it, like, by asking them, and, and C, you know, they have permission to go backwards, stay where they are, go forwards to, to whatever degree, and, um, and I think that, uh, I think that the kids, um, I think there are kids who are a little bit timid at the beginning, and they don't feel, they can, I, I feel that there is a group of kids who say they're non binary because they're not, Really ready to go full on.

And as they go, they actually find, no, this is working for me. I'm, I really actually do want to go to the, to the end of the binary there. But, um, I think, I think you just got to let kids have that, that permission to do that.

## CLIP 30

**Ren Massey:** I'll just add in that, uh, this actually reminds me of a successful 30 something I have, um, you know, who's, uh, very accomplished in their field and is, uh, was first aware in the last few years really more about their gender identity and, um, thinking, you know, they were identifying as a woman. Uh, and when the first came really more open to their awareness about six months ago.

Um, took him a couple months to call me, then a couple months on my waiting list. And I've been seeing the person, I don't know, a couple months now. And They were hesitant to acknowledge maybe a non binary space might be good, maybe a fluid space might be good. And it's hard to tell how much feels true to their gender versus how much is external factors, and that's kind of stuff we're sorting through with time.



Um, and I think they're feeling some relief to know that there are a range of medical options, and we're not, The, the fortunate thing is this person is not in a rush rush and has some ways of being able to express, um, their feminine side, uh, with their significant other and friends and, and one of their family members, uh, from their family of origin.

But, um, I, I, my main point is in adults as well as young people. I mean, mature, more mature adults, like 30 somethings.

All right, so if we don't have any other comments on this one, actually, I would really like it if we could get to the next case and then we could close up.

## CLIP 31

**Dianne Berg:** I'm just noticing that Jameson is telling us that we should talk, look more at the chat. Jameson, is there a particular thing?

Jason: I was just wanted to draw your attention to the Q& A box as well as the chat. There are questions in the Q& A stream as well as in the chat. So just, just to make sure that.

**Dianne Berg:** Thank you. I didn't even know about that.

Jason: Yep. Yep. I've answered a few, but, um, the clinical ones I can't.

**Dianne Berg:** Okay. While we look at the q amp a there's a couple coming up in the chat just about that embodiment discussion. Yes. It's, it's a, it's a growing edge for me. And so I certainly don't want to. To misspeak, but my understanding and what I'm trying to kind of incorporate in my clinical practice is in some ways moving away from, um, what is your identity and therefore because you have this identity, you're going to want to do these particular medical interventions to change your body, not having it be as identity driven, because I think that's been the historical basis of kind of how things have operated.

And instead, regardless of your identity, What, what do you think about your body and what do you want your body to be able to be and how do you feel in your body and,

and what's going to help your, your, you feel better about being in your body and how do we address some of that? Um, regardless of what your identity is, and that might mean medical, that might mean lifting weights, that might mean eating better, I mean, there's a whole range, but it just kind of goes shifting your thinking from identity driven interventions to more, um, for some people, more body driven interventions.

It is kind of my, is what I would try to say about that.

## CLIP 32

**Ren Massey:** Kind of related to that, Dianne, there are some questions about co occurring diagnoses or considerations in the Q& A section, and I would just say it's hard to do it justice in a little bit of time here, but, you know, when there are co occurring conditions of any type, I am more cautious and take a slower approach in terms of.

Um, questions to in considering both identity and embodiment. Um, and, you know, may ask people and encourage people to look at things from all of those kinds of perspectives. Um, and maybe try to get creative in asking them to. You know, just as an example, who is somebody who you'd like to look like who, um, not somebody who's a TV star who's super attractive, but just like kind of an average looking person, you know, um, so that we're not engaging in a fantasy realm of transition expectations with like facial hair, no facial hair, chest of wet socks, flat, brown, small, wet.

And, um, sometimes those discussions. are very helpful, especially with folks who may struggle with the identity piece. Um, and, uh, I think that also just we have to be careful when we recognize there are folks who may have things that make understanding identity uh, more fluid or complex or more challenging.

So I just Take a lot more caution. That's what I would say.

Alright, um, I'm going to try to get us to that very last one.

## CLIP 33

**Dianne Berg:** Not wanting to take up more space, but since other people aren't jumping in, I think it just speaks to the importance of the intersection between sexuality and gender and how, um, I think that the field of gender, it feels like the fields are very separate as someone who's in both of ASAC certified person.

I'm, you know, I go to a lot of the sexuality conferences that are starting to. Care more about gender and I think in the gender conferences. There's there's very little focus on actually sexuality and so I think for me this case just Exemplifies a way that they intersect and I think there's lots of ways that they intersect and I know that WPATH Is gonna do a specialty thing on sexual pleasure which I think is is awesome and And so I think just for me, I want to, I just want to point out that that, that intersection, we don't, we don't often do a good job with that.

And I think that's someplace that we could, that we could be doing better.

**Dan Metzger:** You know, I totally agree. And I'm sure putting a kid on a blocker at age nine, and then letting them get to the age of whatever, when they're developing a sexual identity, can that be. Uh, cannot be great, right? So I think I think that the other people brought this up that we are to a degree robbing these kids of that sort of early to mid pubertal sexual stuff that's happening with their with their cisgender peers.

That's not happening because we've got the one loop running and their you know, their brains are just not thinking that way. There's no, you know, they're getting older and smarter about, you know, math, but they're not learning how their body works. They're learning how to masturbate because they don't, because they don't have the urge to do that, right?

And all of a sudden they're, you know, they're, they're way many years behind their peers trying to like figure their sex stuff out.

## CLIP 34

**Ren Massey:** Yeah, I'll, uh, add somebody asked when that sexual health workshops going to be, um, we're in the process of developing a number of new workshops this year. Um, as we're updating the foundations curriculum for Montreal, where we'll present the SOC eight, um, based, uh, foundations course for the first time.

Uh, in the meantime, we have a number of. Uh, workshops this summer, including the one Dianne referred to on sexual health, and I believe it's going to be July 29th. Um, I'm pretty sure that's the date we got lined up in, uh, I'm trying to remember. I think it's like eight to 11 Pacific time, 8:00 AM to 11 Pacific time.

But, um, I'm, I'm not gonna bet my life on that. Um, but um, we also have. Some other comments about sexuality and neuroticism, not neuroticism, eroticism. Um, and, uh, you know, I think that that is some of the complexity of gender and sexuality. Both being processes of discovery and evolution, um, for a lot of, you know, tweenagers and teenagers.

And, uh, so it's not surprising sometimes that they need some help discerning those things. Looks like you wanted to say something, Dianne.

**Dianne Berg:** Well, I think for adults, historically, if, if people with some sort of gender. Identity have, have, have mentioned anything about their sexuality, it, um, or if they there's always been, at least I have had many clients tell me, I did not tell you the truth about, about a lot of things about my sexuality, because I figured if I told you that.

You would gatekeep and assume it was a fetish or assume it was, um, you know, some of the terms that we no longer are using. And so I think there is a huge historical context. To to sexuality being seen as a being seen in a way that does act that does create barriers access to access to care, and I just want I think it's very important that we acknowledge that historical context, um, and that we work against that historical context, um, by talking more about positive sexuality and pleasure and that that they can go together and that it's okay.

Um, and not create barriers to care because people have that belief that that's what we're going to do.

## CLIP 35

**Jamison Green:** Yes, and gender and sex are two different things, but gender informs your sexuality tremendously. And, uh, no matter who you are, trans people, cis people, male, female, non binary, all those things are really informative to each other. And



when you deny any aspect of it, you are limiting yourself. Uh, to a certain extent, you're, you're cutting off parts of yourself if you pretend it doesn't exist.

And clinically, we've been told, trans people have been told historically, Oh no, don't talk about that. So, it's really, really something that our professions need to combat. Thank you, Dianne. That's good.

**Ren Massey:** All right, so I'm going to end with a question. I'm going to stop my screen share here, and I'm going to bring this up to my panelists really quickly.

If anybody has any closing thoughts, one question that we didn't get to was steps to support folks who have regret or interventions. I think it's such a new area. We don't have data on it. to my knowledge, but it looks like a lot of folks are looking for support and I would say we need to normalize their exploration just as we would normalize people considering transitioning to a gender different than what they were assigned at birth and to get them supports to do that.

Um, and again, try not to other, other people in the process, not to marginalize or. Put down other people. If other folks have a quick comment.

All right, that that's to be continued in our ongoing growth in the field. I want to thank all of the attendees. Uh, I appreciate the great input, the questions, the comments, the exchange, the thought provoking, um, dialogue among all of us. I want to thank the production staff, Mike Evans and Cheryl Field.

Y'all are awesome. And our WPATH staff as well, Tricia, Kat, Rebecca. Wayne and Jamie. Uh, I see Tricia, Kat, and Rebecca doing the heavy lifting today. And then I thank all of my colleagues for being here and the thought you put in in advance and for taking part in this conversation to try to advance health care for our trans and gender questioning clients.

Thank you.

23) APPENDIX: ADDITIONAL FILES

THE FOLLOWING FILES WERE SHARED WITH ENVIRONMENTAL PROGRESS BY A SOURCE OR SOURCES AFTER OUR REPORT AND INITIAL ANALYSIS WERE COMPLETED. WE HAVE ADDED THESE ADDITIONAL FILES BELOW AND ENCOURAGE THE READER TO REVIEW THEM AS WELL.

a) *A WPATH member seeks guidance on transgender client who presents with traits associated with autogynephilia*

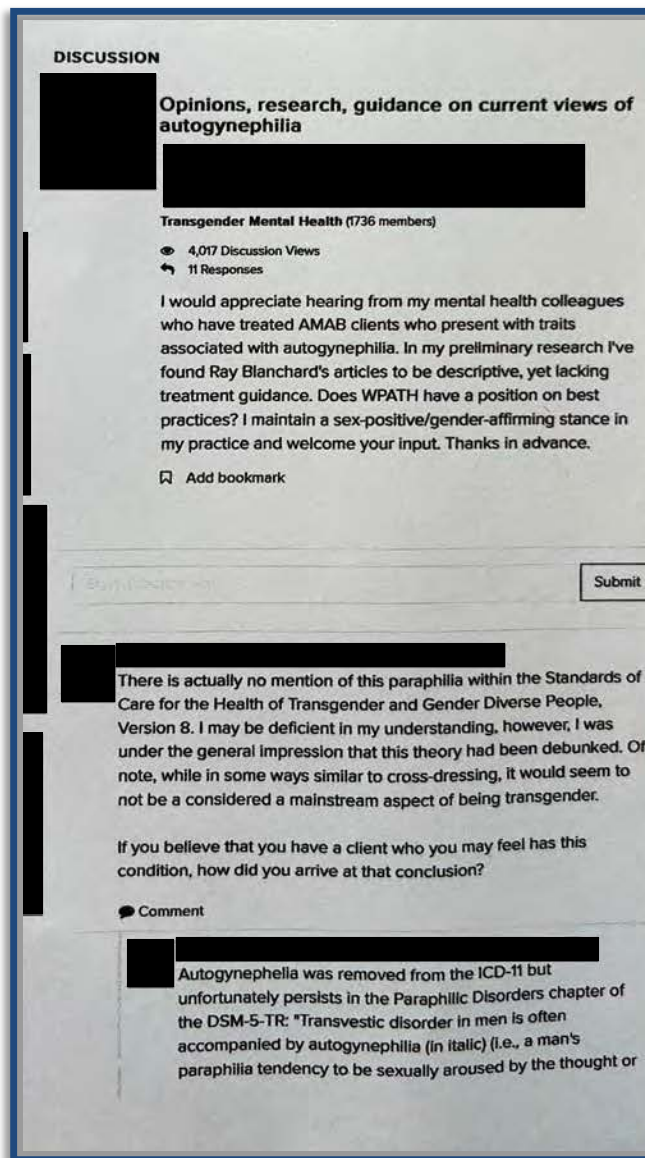


image of himself as a woman). Autogynephilic fantasies and behaviours may focus on the idea of exhibiting female physiological functions (e.g. lactation, menstruation), engaging in stereotypically feminine behaviour (e.g. knitting), or possessing female anatomy (e.g. breasts).<sup>6</sup> (DSM-5-TR, p.799)...

[Read more](#)

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**[REDACTED]**

Blanchard's theory of autogynephilia is no longer widely accepted in trans health (if it ever was) and is widely considered transmisogynistic, so resources on it that are sex-positive and gender-affirming largely do not exist.

[Comment](#)

---

**[REDACTED]**

Hi. Don't know where you read what you read about autogynephelia but it's been long debunked. Blanchard's flawed and biased concept had been a topic of debate and controversy within the field of gender studies and transgender healthcare. The so called research is poorly executed and biased. Many researchers and clinicians have criticized this concept for several reasons, including concerns about its validity and potential stigmatization of transgender individuals.

WPATH and other leading organizations do not consider autogynephilia as a valid or useful diagnosis. Instead, we focus on...

[Read more](#)

[Comment](#)

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**[REDACTED]**

Realized after sending this, that it may not have been very helpful to you in your legitimate quest to offer your clients assistance in their exploration of their gender identities and expressions. In my experience, what Blanchard attributed to the bogus concept of autogynephelia is related to the diversity of gender identities, presentations and experiences of trans and gender diverse folks, including sensuality, sexuality, and attractions. Helping your clients explore what works for them, giving them permission to explore and embrace the diversity of attractions and expressions and understanding that many of these experiences are interconnected a...

[Read more](#)

[Comment](#)

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**[REDACTED]**

As a gender doula, I work with folks who are feeling confused and/or distressed by the way their gender intersects with their erotic life. I find that folks of many genders (including cis het folks) find various forms of gender affirmation to be extremely erotic. Pathologizing that as a "philia" of any kind is not helpful.

Others have already pointed out that autogynephilia was a discredited theory and is not useful as a framework in trans therapeutic support. But I would add the above as an approach for supporting a client through the erotic aspects of gender affirmation. It is often considere...

[Read more](#)

[Comment](#)

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**[REDACTED]**

For a clear challenge to the very outdated and stigmatizing notion of autogynephilia, I recommend Julia Serano's excellent article on the question: Autogynephilia: A scientific review, feminist analysis, and

alternative 'embodiment fantasies' model  
[https://journals.sagepub.com/doi/abs/10.1177/0038026120934690?  
journalCode=sora](https://journals.sagepub.com/doi/abs/10.1177/0038026120934690?journalCode=sora)  
([https://journals.sagepub.com/doi/abs/10.1177/0038026120934690?  
journalCode=sora](https://journals.sagepub.com/doi/abs/10.1177/0038026120934690?journalCode=sora))

Comment

My experience with clients who persist in delving into this long-ago debunked theory...is that it is damaging and in no way does it aid them to attempt to box themselves into Blanchard's "made-up" categories. My advice would be to encourage open exploration and resist labels. Clients can be much too hung-up on labeling before they give themselves free reign to explore.

Comment

Rather than focusing on the negative problems with transgender theories of Blanchard in Toronto, Bailey at NW or Money at Hopkins, I feel that providing counseling seeking out transgender role models needs to stress the positive. Among those superb stars, I suggest Lynn Conway, PhD, an early day computer genius, member of the National Academy of Engineering and Professor of Electrical Engineering at Michigan. Her remarkable website at [www.lynnconway.com](http://www.lynnconway.com) (<http://www.lynnconway.com>) has in-depth sections that include bios of 200 successful transgender men and women. Her proquoem begins "Your time is limited, so don't waste it living someone else's life" Stev...

Comment

A few musings. The funny thing about autogynephilia is that it did not account for the profound transgender feelings of small children (ages 4-7 or so).

Lynn Conway is a fantastic role model. She has achieved so much.

Thank goodness the old criteria, and John Money are not factors at this point.

Comment


Hi [redacted] if something is identified as a problem, it might really be a problem, no matter what it ends up getting diagnosed - and needing treatment. I have run across one case in my 16 years of practice that had me a little stumped and it led to an active goal of ceasing crossdressing due to how damaging it was to the individual's life. He was an upper middle class, cis, hetero, man with a history of intermittent crossdressing (and polysubstance use recovery), but upon years of gender exploration together, it really presented as a more pure arousal of seeing self as a very sexy "prostitute" with the chase of the thrill - part of this thrill was leading to dangerous behaviors (nearl...

Read more

Comment



pure arousal of seeing self as a very sexy "prostitute" with the chase of the thrill - part of this thrill was leading to dangerous behaviors (nearly failing college/work impact d/t periods/days of constantly changing undergarments, times of driving 80 miles an hour while rapidly changing clothes, stealing anything from bras to even a wedding dress, manipulating others with stories to get more "sexy" validation vs gender validation). He determined the need to cease and we did work on that with overall success and reported benefit. We followed treatment planning similar to substance abuse treatment and we found that an SSRI assisted with the intrusive/oc thoughts that he was having. Good on you for reaching out for consultation :)

 Comment

b) *A WPATH member seeks guidance on patient who identifies solely as a heterosexual male with autogynephilia*

**DISCUSSION**

**[REDACTED] Patient presenting with self-identified autogynephilia**

[REDACTED]

**Non-Surgical Transgender Healthcare (969 members)**

👁 1,616 Discussion Views  
 ↩ 6 Responses

I am well aware of Blanchard's debunked concepts related to gender dysphoria, and do not ascribe to the concept of autogynephilia. However, I have a patient who identifies solely as a heterosexual male with autogynephilia. This person has been taking hormones off-and-on for 15 years. Admittedly takes them for about 9 weeks at a time, while withholding sexual gratification, will sexually gratify himself after 9 weeks of taking hormones, and will then have "clarity" about his "perversion." During that 9 weeks, this person will seek out anti-trans activists, and anti-gay activists to have meetings as a form of self-punishment. Once they have stopped hormones, they immediately begin the process of planning to restart again, in secret, as a form of eroticism. The patient is admittedly staunchly conservative and religious, and is a part of legislative bodies that work with "anti-grooming" groups in an attempt to "de-trans" children. I am seeking guidance if anyone else has experience with this, and what people would recommend as far as continuing care. I work at an LGBTQIA+ health center which predominantly provides gender-affirming care, and I have concerns regarding continuing to provide hormones for this person. Any feedback or guidance would be most helpful. Thank you!

🔖 Add bookmark

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[REDACTED]

Submit

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[REDACTED]

Hi [REDACTED] I'm actually local to you (I work at [REDACTED] and work with [REDACTED] and some other folks at both [REDACTED]), feel free to shoot me an email and we can talk, I

have some ideas and people I could put you in contact with.

Comment

I have had two previous clients with similar presentations that, after MUCH time, were able to slowly peel back the layers. I think many may try to use autogynephilia as an "acceptable" reasoning rather than face the extreme internalized transphobia they are experiencing.

Are your concerns providing the hormones from a medical perspective or providing care to someone who is so transphobic? I am asking out of curiosity for medical implications and I hope you do not read that as a challenge. I ask because if this was my client, I would not try to interrupt that pattern if they are aware of the potential risks and permanent changes but would not be ok doing so if there were more risks associated with a stop and start. My point for not stopping them is that I would want to be able to process with them through their cycles to have the client have to work through the dissonance. Timely process for sure!

Comment

Hormones are for people seeking gender affirming care. This person isn't seeking gender affirming care but wants hormones for the sake of a fetish. I also share your concerns about continuing to provide hormones for this person. Additionally, I am further concern at the level of cognitive dissonance between this person's actions and values. Self-harm and suicidality are major issues for anti-trans conservatives who dabble in LGBT spaces and behaviors. For this person, I would recommend that they obtain a therapist letter that addresses these issues prior to further HRT. Full disclosure is that I am a therapist, not a nurse practitioner.

Comment

I mainly have questions, and not guidance at this point in my understanding, although the theme of conflict is prominent in your description. Is this person taking estrogen in the 9 weeks? Does their internal gender identity/expression change in any way while taking hormones, and if so, how? What is their described relationship to the concepts of femininity and masculinity? In themselves? In others? When they seek out punishment, is it for a "perversion" of engaging with feminine aspects of themselves? Or, for being sexually aroused by their own femininity? Or for using hormones? Or something else or all of these? Have they been in a sexual relationship with another person? How is their capacity for emotional and physical intimacy expressed in non-sexual and sexual relationships? Are hormones needed for any sexual arousal?


Comment

One more question I have: why are the cycles of no-hormones and hormones 9 weeks long?

Wow. I can certainly understand your alarm bells. Appears to me if this client is locked in a vicious circle, and I have no idea as to how to interrupt this cycle, however perhaps, figuratively speaking, without abandoning them, you do need to "stick your professional foot out" and trip this person up. Perhaps a religious approach may work, "this confusion in your life, you think that is what God wants?" "There is a



physical and genetic component to trans. Its not a defect, it is part of God's biology. It cannot be wrong to explore that!"....type of logic/reasoning.. I am a "devout bead rattling Catholic" and have no problems between me and God, simply because I have good self-talk that I am convinced He has given me.... Whatever keeps this poor soul going around in circles has to be a lie. Your job is to figure out what that lie is, and the usual culpret is someone else is feeding them religious crap. Sincerely hope this has helped. I very rarely speak about my faith or God, but as you said, religion and conversion crackpots are part of this puzzle.

 Comment



c) *A WPATH member seeks clarification on comorbidity versus differential diagnosis for client with gender dysphoria and schizophrenia*

**DISCUSSION**

**Comorbidity versus differential diagnosis of schizophrenia in client with gender dysphoria**

Transgender Mental Health (1736 members)

4,526 Discussion Views  
8 Responses

I have a client who meets DSM-5-TR criteria for gender dysphoria. They take a medication prescribed for bipolar disorder although they have not told me they have that diagnosis. Their presentation is atypical from my experience. They presented for intake with a beard, stating they identity as a woman. They have extremely circumstantial speech, flights of ideas, and loose associations, but I have not observed a/v hallucinations or delusions—as I understand them. Their appearance is consistently disheveled, and their hygiene is extremely poor. However, their self-report of their gender identity seems to me to be wholly inconsistent with their presentation. I am wondering if they might have schizoaffective disorder or schizophrenia. I would appreciate some references to literature reviews or authoritative articles about comorbidity of gender dysphoria with schizoaffective d/o or schizophrenia versus differential diagnoses between gender identity incongruence and schizophrenia. I have been treating transgender and gender-diverse clients since the 1980s and I have never observed a woman assigned male at birth to present for treatment appearing this way. They did recently began taking estradiol 2mg q.d. My clinical observation is that there is something "off" and I can't put my proverbial finger on what it is. Any ideas?

Add bookmark

Hi [REDACTED] I don't know of studies on this, but wanted to just note that I've met a few folks dealing with homelessness and schizophrenia

who are also trans. If you have contacts who work for big agencies you could reach out to, that might be reassuring? Good luck :)

Comment

Thank you, Great idea.

It seems like the timing of how various symptoms line up (or don't) would be important. I can't necessarily comment on the quality of these resources, as I only glanced at them, but they might be a place to start: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC37424613/> (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC37424613/>), <https://www.sciencedirect.com/science/article/abs/pii/S0165178121005679?via=ihub> (<https://www.sciencedirect.com/science/article/abs/pii/S0165178121005679?via=ihub>) (couldn't read this one as it's behind a paywall). Interesting to remember that neither hallucinations nor delusions are...

Comment

Thank you. Yes, I guess my ignorance was showing. I mistakenly assumed a dx of schizophrenia required delusions or hallucinations. It helps to know that. This client's speech is incredibly disorganized, and it is an issue on which they wish to work.

Invite

If you are worried that the reason for your client's gender incongruent feeling is actually a mental health issue, you might want to talk about referring them to a psychological diagnostics to have that confirmed or ruled out. You might also want to take into account a DID that often presents with schizophrenia-like symptoms. Also keep in mind that "our" idea of how a woman would present herself to others might not be applicable to your client. Especially if they are homeless, they might not have the possibility to, for example, shave, get other clothes etc. Moreover, the appearance of your client does not necessarily represent their gender identity. If there is no time pressure, I would encourage you to just take your time and observe whether the "off-feeling" starts to change and, if so, in what way. Just one additional comment regarding the term "comorbidity". Since gender incongruence is not classified as a morbidity (anymore), we should refrain from using that term. As any person with a certain gender identity may have mental health issues, so can gender incongruent people. Good luck!

Comment

I agree with that the appearance doesn't mean much. These days, it's increasingly common to present incongruously; as the transitioning process progresses, the appearance may catch up... or go in the other direction. In fact, most of my clients who present very binary often eventually move toward nonbinary appearance. You can gauge the client's interest in presenting differently, name change, etc., which might lead to a more interesting exploration of just what her gender feelings are.

I'd be curious to know how the client responds to estradiol and its physical effects; that's probably much more diagnostic.

But, then, there is the disorganized speech...

Disorganized speech/presentation could be a wide range of things, including (long-term) substance use, autism, ADHD, psychosis, DID... so it'll take all your diagnostic muscles to sort it out. I would start with the presumption that it is separate from gender; once you have a better handle on it, you will know better how it does or does not intersect with gender.

Technically, pedantically, I would say the person does not actually meet the full diagnostic criteria for gender dysphoria until other factors are completely sorted out... but, then, there is also no harm in client starting hormone therapy at a low dose, see if it helps or not. Beware that higher doses of estradiol can exacerbate the client's emotional imbalance, if any, so I'd advise the prescriber to proceed very, very slowly.

Comment

Hi

Thank you for your input. My client is not homeless and it is one of the things I would consider. As for comorbidity, gender incongruity is classified in ICD-11 as a sexual health issue, and in the U.S. (where I work) as a DSM-5-TR diagnosis. Therefore, comorbidity would be a correct term to describe the simultaneous occurrence of two diagnoses, whether physical or mental.

Comment

"Comorbidity" has a strong pathologizing background. Try using "co-occurring," which suggests things are occurring together without cause or pathology attached.

d) A WPATH member discusses surgical complication of transgender patient after top surgery

**DISCUSSION**

**[REDACTED]** DRESS Dx Situation w/top surgery  
**[REDACTED]**

Gender Affirming Surgery (486 members)

👁 493 Discussion Views  
 ↩ 2 Responses

A transmale patient of mine (in his early 60's) had successful chest surgery about 7 weeks ago. 3 weeks postop he suddenly developed a rash that began at the surgical site, and then quickly spread up and out, under the arms, the compression vest, and progressed down to the groin and lower legs. He also has well-managed Type 1 Diabetes.

He went to Urgent Care where it was discovered he was very jaundiced and was Dx'd with DRESS (Drug Reaction with Eosinophilia and Systemic Symptoms), which was then attributed to the antibiotic cephalosporin (cephaloxin family) that had been administered with the anesthesia. He was Rx'd high doses of prednasone for the rash - which has lessened but is still causing a lot of discomfort 4 weeks later.

My patient has since found rather a large amount of similar reports on Reddit (see:  
[https://www.reddit.com/r/TopSurgery/comments/s41dwp/documenting\\_my\\_allergic\\_reaction\\_more\\_info\\_in/](https://www.reddit.com/r/TopSurgery/comments/s41dwp/documenting_my_allergic_reaction_more_info_in/)  
 (https://www.reddit.com/r/TopSurgery/comments/s41dwp/documenting\_my\_allergic\_reaction\_more\_info\_in/))

Invite ☰ Our concern is that there seems to be no accountability for this occurrence: was it an protocol or practice error of some kind that should not have happened? Nobody affiliated with the surgery has offered any kind of explanation of concern. While not interested in any legal recourse (yet) we are wondering how to address this, and would appreciate any supportive guidance. If the community here deems it important to i.d. the medical facility and surgeon by name here, let me know.

thanks all,  
**[REDACTED]**

🔖 Add bookmark



[REDACTED]  
Hi!

It seems an allergic reaction to the antibiotic administered. It is always possible. Good that he referred to urgent care and he received adequate medications. The supportive guidance is that he should disclose the reaction at next medical consultation, and eventually be tested for allergy to the antibiotics.

Strange that he developed the reaction 3 weeks later...

Anyway, everything is possible following medications and surgery, including anaphylactic shock to drugs, as well as necrotising fasciitis following surgery or minor trauma. You can check up these two conditions.

Our work is difficult ! But we must do it! For the benefit of the patients !

Comment

[REDACTED]  
Thanks very much for your sensitive comments. My patient reports reading that many others report the same delay in symptoms of several weeks - of course this is anecdotal and to my knowledge there has been no focused research on such issues yet.

However – Is it not odd that such a possible adverse and potentially dangerous reaction was not assessed before the surgery?

Please feel free to continue to add to this conversation as you ponder it. I have posted this case before the Surgeon's Group here at WPATH, and am looking forward to their responses, too.

e) *A WPATH member seeks advice on sending patient to a philosopher to help change their views on gender identity*

DISCUSSION
OTH

### Treating unhelpful ideas question

**Transgender Mental Health** (1736 members)

👁 7,562 Discussion Views  
🗨 18 Responses

I've got a terrific client who's pretty hung up on the idea that identity is discursively, socially constructed. (She's a guy, will always be a guy, because society sees her that way.) I don't think my arguing against this stance will be fruitful, I'm not versed enough to be confident at it... and this is a super normal phase for lots of people. I've encouraged her to try out talking to other trans girls, or to try out watching videos of other people's experiences with this, and she's not ready. Fair enough! This is probably "my stuff," and it might be a dumb or difficult idea, but I'm thinking of referring her to a philosopher (she's near a couple good universities). Feedback requested: how dumb/difficult is this idea? Any leads, or better ideas?

Add bookmark

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Submit

1) I wouldn't send her to a philosopher unless you personally know a philosopher who is pro-trans "and" versed in academic gender theory. There is a complex history of gender-as-performance and gender-as-social-construct theories that could be helpful, but it can also be a disempowering rabbit hole that goes to some dark places.

2) I would evaluate the client for dysthymia and autism.

3) She is absolutely right. The whole point of gender transitioning is to change how "society sees her", and, ergo, her "external" gender identity, which will then be consistent with and affirm her "internal" gender identity. Social construction of gender means that gender arises from a complex interaction between individual will/action and social conventions/reactions; this makes the process challenging, but

through the morass of cognitive dissonances... which are necessary for any kind of social change... hence the recommendation to evaluate for her for dysthymia/autism, i.e., her response to seeming contradictions.

4) It may simply be that her desire to be more congruent is not strong enough to clearly outweigh the obstacles. If so, it just isn't time... if it ever will be.

Hope this helps!

Comment

Thanks, [REDACTED] That is helpful :)

If it's rooted in recognition in that way, what does the client make of the fact that plenty of people recognize trans women as women? Or the fact that they may not even be recognized as trans at all in the first place? The thing with recognition-based accounts is that people actually don't have consistent criteria for gender!

My feeling is that the client may be overintellectualizing what is essentially a form of self-doubt and internalized transphobia. If so, I'm not sure philosophers would help much.

Comment

Exactly

The "idea that identity is discursively, socially constructed" comes from the work of Michel Foucault, a French philosopher. Rather than referring her to a philosopher, I would recommend reading Loizos Heracleous's book, "Discourse, Interpretation, Organization," in which the author discusses Foucault's conceptions of discourse and its relationship with power and sociopolitical interests. I would also suggest reading Foucault's "Discipline and Punish." Here is a YouTube video ("Michel Foucault's Conception of Discourse as Knowledge and Power") that will help get you started on the road to being versed enough to be competent (and hence confident) at discussing this wit...

Read more

Comment

Wow, thanks a bunch, [REDACTED] I'm going to start with the University Quick Course youtube you recommended and marinate on the idea that we must take an active role in negotiating the presentation of self. I like it, and I want to think more about the implications there. Thanks again :)

I understand your problem! To refer her to a philosopher might be a good idea, but it might be an advantage that this is a competent philosopher.



f) A WPATH member seeks guidance for client whose libido has drastically increased on testosterone

DISCUSSION OTHER

**Effects of testosterone on libido and trans sex education**

Transgender Sexual/Reproductive Health (1025 members)

1,022 Discussion Views  
4 Responses

Hey everyone,

I am a mental health therapist and I have a freshly turned 18 yr old transmale client with autism who just started testosterone in late August. previously they always believed they were asexual and had zero interest or desire for physical intimacy. Since starting T they have been coming to session reporting their libido is 'through the roof' and they can't stop being 'horny'. I've been able to normalize the increased libido, but my client was wondering if this will eventually even out or come back down at least a bit? If so how long? If not, any recommendations on how to best adjust to this new found sex drive?

I plan to do some sex education and human anatomy lessons as the client is new to anything related to sex, intimacy, arousal etc. I'd love any sex education resources you all have for transmasculine individuals.

Thanks in advance!


Invite  Add bookmark

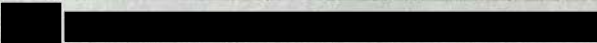
Submit

I have a resource for trans men who specifically have sex with other men: <https://www.rainbowhealthontario.ca/resource-library/primed-the-back-pocket-guide-for-trans-men-and-the-men-who-dig-them/> (<https://www.rainbowhealthontario.ca/resource-library/primed-the-back-pocket-guide-for-trans-men-and-the-men-who-dig-them/>)



I don't know that it will answer your client's question, but it does have some generally good information overall. If I run across any other resources during my travels, I'll try to post them here.

 Comment

  
I should have added, it's written in pretty frank vernacular, presumably to be more approachable for the target audience, but if you don't expect that it could come as a mild shock.

  
Hey 

Speaking from my personal experience, yes, this will calm down. For me, it's helpful to remember that starting HRT is essentially the same thing as going through puberty, so your client is currently a lot like a 13-15 year old boy. Adult cis men don't have the same libido they did when they were 15, and neither do trans men or transmasculine people once we're past being hormonally 15. I can't speak with a lot of precision about how long it might last, but I'd say it's most intense in the first 6 months to a year (again, based on what I remember from my own experience, which was almost 20 years ago now). Maybe an...


[Read more](#)

 Comment

  
Dear 

As a therapist that predominately works with Trans, Non-binary and Gender Diverse clients/patients. I see this alot. It can be distressing for an asexual person, however completely normal when on testosterone for the beginning stages. Masturbation education is key, encouraging that it is completely natural and normal to self satisfy and soothe. If they have a partner discussing having the conversation with their partner of their increased libido and sex drive, but not placing pressure on the partner to satisfy. Yes this will eventually ease and 'normalise' to a new level for them in their affirmed gender. Everyone...

[Read more](#)

 Comment

Hey [REDACTED]

Speaking from my personal experience, yes, this will calm down. For me, it's helpful to remember that starting HRT is essentially the same thing as going through puberty, so your client is currently a lot like a 13-15 year old boy. Adult cis men don't have the same libido they did when they were 15, and neither do trans men or transmasculine people once we're past being hormonally 15. I can't speak with a lot of precision about how long it might last, but I'd say it's most intense in the first 6 months to a year (again, based on what I remember from my own experience, which was almost 20 years ago now). Maybe an endocrinologist can speak on this question with a broader knowledge base.

I hope this is helpful in supporting your client as they try to adjust to their new experience of their body and figure out what to expect in the future!

Comment

Dear [REDACTED]

As a therapist that predominately works with Trans, Non-binary and Gender Diverse clients/patients. I see this alot. It can be distressing for an asexual person, however completely normal when on testosterone for the beginning stages. Masturbation education is key, encouraging that it is completely natural and normal to self satisfy and soothe. If they have a partner discussing having the conversation with their partner of their increased libido and sex drive, but not placing pressure on the partner to satisfy. Yes this will eventually ease and 'normalise' to a new level for them in their affirmed gender. Everyone is different and it last varying times for each person. It is a 'second' puberty but a 'first' puberty in their affirmed gender, so it's about exploring with them the 'newness' in the experience of being. Doing alot of somatic body work and being in the here and now. it's important for them to explore their sexuality now at this stage providing psychoeducation that sexuality is fluid and every changing and may now be abrosexual i.e. fluctuating between being asexual and then not sometimes. Don't make things too clinical and medical, it's all about the experience.

queersextherapy on Instagram would be most suitable for them especially that they are a young person. It provides body positive, quick, easy and simple psycho education on the matter, and recently did a post a couple of weeks ago on being asexual and experiencing sexual desires that may be overwhelming.

I also specialise in GSRD, I don't know where you are based but I am happy to see clients online as well, for short periods if needs be. I have a programme called [REDACTED] where they can see me for 6weeks or more for focused support within their transition.

Comment

g) *A WPATH member seeks guidance to better support polyamorous lifestyles within the transgender and gender non-conforming population*

**DISCUSSION**

**Training and Resources for Polyamorous Transgender Patients**

3,349 Discussion Views  
10 Responses

As I start a private practice, I am looking for ways to better my knowledge and ability to support polyamorous lifestyles within the trans and gender non-conforming population I see.

As we know, people who are part of this population are often forced to create their own family environment and polyamory often constitutes this family dynamic. I believe that as acceptance continues to evolve, we as providers will begin to see ourselves needing to support multiple people in a relationship dynamic. I have found that the isolation of covid has, for some, increased the desire to have more members in a polypod or polycule.

Do other clinicians have a sense that this is an undercurrent movement in the LGBT community that will continue? Does anyone see this movement happening? What are some options for training that you are getting or that you recommend?

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I have begun to bring this up in trainings that I do around LGBTQ+ care. I don't think we have the shared language around the variations in polyamory quite yet. I think there are a lot of elements that can be assessed - sexual, romantic, nesting, child rearing/having - and that is before you get into the variations in exclusivity or other explicit commitments (marriage, unions, bonds, etc).

I'd love to hear if there are resources out there to better understand

and support our polyamorous folks. As a family doctor, I am very keen on understanding the relationship and family dynamics and this has certainly been an area needing growth for me.

Comment

Yes, check out my response below for possible further training, and as others have mentioned, the book Polysecure and the podcast Multiamory are also great!

These are interesting questions and I'm eager to hear from others. I am a novice in understanding and working with polyamory so I recently read the book Polysecure by Jessica Fern and found it very helpful as a starting point.

Comment

YES! That's a great rec! Also, the podcast Multiamory!

Many people who identify as LGBT also identify as polyamorous and as we see an increase in the accessibility of platforms and safe spaces for LGBT clients to be vocal about their experiences and needs, we are seeing an increase in discussions around polyamory, kink, leather, and so on. I would definitely agree that it is important to be aware and accepting of polyamorous relationships. For those starting a private practice who want to be gender inclusive, it is also helpful to be sex positive and inclusive of different relationship styles. It is my belief that once we start to question the idea that love is based on gender and that gender exists only in a binary, we realize that so much of what w...

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Comment

YES!

Hi This is a great topic & question! I believe queer communities, especially trans and nonbinary folks, are definitely more open to breaking down some of the historically white, Western, colonized standards of relationships, sex, gender, and how we love others. So yes, this likely will continue and (with any luck) continue to expand to allow others to examine their own stuckness in some of the harmful structures that amplify the impact of minority stress. In terms of training, [www.affirmativecouch.com](http://www.affirmativecouch.com) (<http://www.affirmativecouch.com>) has a phenomenal training library. I...

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Comment

Also a relative novice myself, but I work mostly with trans folks, and noticed that enough of them (statistically, my gender-expansive clients, who knows why) are in the kink and poly communities. I've read up a bit, and here's what I've looked into that I've found helpful!


-The Ethical Slut, by Dossie Easton and Janet Hardy  
-Mating in Captivity and The State of Affairs, both by Esther Perel (not poly-specific, but helps greatly with relationship dynamics and



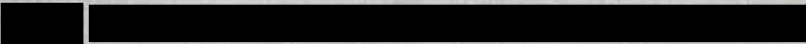
understanding of desire)


-More Than Two, by Frank Veaux and Eve Rickert...

Read more


 Comment


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 It's been both a professional and personal experience (I'm non-binary and polyamorous) seeing a lot of overlap with polyamorous and LGBTQ+ communities. I would also recommend the podcast, *Multiamory*, with the understanding that just like there hasn't been a single universal template for trans-ness there isn't a universal template for polyamory either.

 Comment

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 Seconding the recommendation for the book *Polysecure*. Several of my clients have mentioned that it helped them immensely. I'd also recommend the workshop "Trauma-Informed Polyamory" (<https://www.clementinemorrigan.com/product/trauma-informed-polyamory-workshop>).

 Comment

h) *WPATH members debate the conclusions of a new research paper on the harm of gatekeeping transgender people from gender-affirming care*

**Must Read Article: Important New Paper on Gatekeeping as Harm Concludes Gender Assessments are Useless Barriers to Care**

4,099 Discussion Views  
9 Responses

Hi all,

There is a new, exciting, and important read about the harm of gatekeeping trans people from gender-affirming care. The paper reviews the literature on gender assessments, and its authors conclude that attempts at assessing people's gender identity and/or dysphoria are not more effective at preventing regret in accessing gender-affirming care than self-report and that assessments are based on stereotyping, arbitrary, and unproven considerations.

Per Florence Ashley, one of the paper's esteemed authors, "The paper offers an important rebuttal to jurisdictions like Missouri and Saskatchewan that strive to restrict access to medical or social transition under the guise of needing "careful assessment."

As most of us working in gender-affirming care already know, whether through experience or reviewing prior trans-led research, there is no evidence, as shown here, that lengthy gender assessments confer any mental health benefits.

The paper is attached; there is an audio version, and the pdf is free at the link! Enjoy :)

In solidarity,

Link: (<https://psycnet.apa.org/doi/10.1037/sgd0000672>)  
(<https://psycnet.apa.org/doi/10.1037/sgd0000672>)  
(<https://psycnet.apa.org/doi/10.1037/sgd0000672>)  
(<https://psycnet.apa.org/doi/10.1037/sgd0000672>)

Audio version:

[https://podcasters.spotify.com/pod/show/florence-ashley/episodes/Do-gender-assessments-prevent-regret-in-transgender-healthcare--A-narrative-review-e2ana4b  
 (https://podcasters.spotify.com/pod/show/florence-ashley/episodes/Do-gender-assessments-prevent-regret-in-transgender-healthcare--A-narrative-review-e2ana4b))  
 (https://podcasters.spotify.com/pod/show/florence-ashley/episodes/Do-gender-assessments-prevent-regret-in-transgender-healthcare--A-narrative-review-e2ana4b  
 (https://podcasters.spotify.com/pod/show/florence-ashley/episodes/Do-gender-assessments-prevent-regret-in-transgender-healthcare--A-narrative-review-e2ana4b))

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Thank you for letting us know about this article. As a woman assigned male at birth and a clinical social worker, I disagree with the authors' conclusions that clinical assessments unnecessarily impede a person's access to gender-affirming care. The point of these assessments is not to gatekeep access to care. It is to help the person seeking care assess the relative risks and benefits for themselves. Doing otherwise violates a patient's rights to self-determination. As part of evaluating the risks and benefits, providers have a responsibility to inform the patient that there is a small possibility that they may regret their decision, however strongly they feel about proceeding at the time. This is no different than informing a patient that death a risk, however small, of any surgical procedure. Moreover, as half of the participants in Littman's (2021) study emphasized, they felt that inadequate assessments were responsible for beginning gender-affirming care that they now regret. It is true that some providers perceive their role as gatekeeping to the extent that they have the power to deny access to care. In my own case, I saw a licensed clinical psychologist for years, and when I asked for a letter to undergo "surgical sex reassignment" (1996 lexicon), she informed me she would not because I "was not ready." When I asked what I needed to do to appear ready, she literally shrugged her shoulders. This kind of gatekeeping is unethical, as it violates a client's right to self-determination. Ashley et al. (2023) err in arguing that, "Delaying access to gender-affirming interventions for those who are at elevated risk of regret would not be an appropriate alternative to withholding care" because the average time to regret is about a decade (p. 5). To the best of my knowledge, there have been no prospective studies exploring the time to regret, which is the only valid way to determine the time to regret. Assessment may, indeed, take a period of months as one explores the risks and benefits of treatment with a clinician who has expertise in transgender and gender-diverse healthcare issues. However, permitting a patient to begin gender-affirming medical interventions without assessment would be akin to failing to assess the duration of a patient's distress (a core component of all DSM-5-TR diagnoses) for depression, post-traumatic stress disorder, or many other issues prior to making a diagnosis. Given most TGD people cannot access care without a diagnosis of gender dysphoria to meet 3rd party payor requirements, the issue is with the insurance companies, not the providers doing the assessments. The WPATH SOC-7 make it clear that insurance companies need to change their policies to improve access to care. Moreover, the argument that it is unethical to delay access to care because only a small minority will regret their decision to obtain gender-affirming care is as irrational as arguing that any law or policy should be passed despite the potential or probable disadvantage to any marginalized group. This was the kind of thinking



that led to bans on LGBTQ people serving in the military--that permitting the minority access to service would harm the operational integrity of the many. The Red Cross prevented gay men from donating blood because the that small minority was known to be at disproportionately high risk of having HIV that could adversely impact the entire blood donation system. Of course, I am not saying I agree with that policy (I don't). We delay any number of medical interventions because we want to do lab work and other diagnostic procedures to make sure the patient will benefit from treatment. The same should be no different when assessing WITH the patient or client the risks and benefits of beginning gender-affirming medical intervention. In sum, Ashley et al. (2023) mischaracterizes the contemporary reason for assessment. It is not to unnecessarily impede or delay care. It is to weigh WITH the patient the potential risks and benefits of THEIR receiving gender-affirming medical interventions. This is, in fact, a core component of the WPATH SOC-7. Moreover, I would content that many professionals providing gender-affirming care have not received the training required to meet these standards of care. This training and supervised experience is essential to ensuring one is competent to help a patient sort out the risks and benefits of care. I have worked with many TGD patients who decided in the course of weighing the benefits and risks that, like most TGD people, gender-affirming medical interventions were unnecessary or undesirable. I have had patients show up demanding (not merely requesting) access to care because they wanted to "fit in" with their gender diverse peers or because they preferred activities stereotypically associated with a different gender than they identify with. They were not experiencing distress or discomfort for any other reason. Certainly, carte blanche access to gender-affirming medical care could have been viable. However, invariably they stated they appreciated the opportunity to question their motivations. Finally, one point Ashley et al. (2023) make is incorrect. They state the WPATH SOC-7 does not require a diagnosis of gender dysphoria for adolescents for initiation of gender-affirming care. In fact, it does. It states, "The following recommendations are made regarding the requirements for gender-affirming medical and surgical treatment (All of them must be met): 6.12- We recommend health care professionals assessing transgender and gender diverse adolescents only recommend gender-affirming medical or surgical treatments requested by the patient when: 6.12.a- The adolescent meets the diagnostic criteria of gender incongruence as per the ICD-11 in situations where a diagnosis is necessary to access health care." Finally, it seems to me that Ahsley et al. (2023) did their research to prove a point rather than test any hypotheses or systematically review the literature aligned with Cochrane criteria. They certainly make some valid points. However, many of their points seem irrational and inconsistent with providing ethical care. I am 100% in support of gender-affirming care for those who determine they want them. However, I would never recommend care for this care (or any other for that matter) without doing a thorough assessment WITH the patient of the risks and benefits of treatment, an essential part of informed consent for any health care. It is consistent with best medical practices to make these assessments and base one's recommendations on them.

Comment

Thanks for sharing your take on this. Insurance companies are a huge problem - agreed! But therapists aren't required to assess folks who need hip replacement surgery (larger regret rate) or nose jobs.

For clarity, you reference SOC-7, but I think you are actually meaning SOC-8. Could you confirm?



██████████ Thanks for this full some response. As an MD providing care to detransitioners, and as an MD who has provided care for trans adults for almost 2 decades, I completely agree. We have a novel population now, like it or not. If we are not careful, the roll-backs on care at the government levels, in response to a loss or lack of gatekeeping/proper assessments by the system will lead to a loss of services for consenting, fully informed adults. Individuals under 18 (really under 26, in my opinion), are an unknown, especially those with what appears to be adolescent onset GD. We truly have no idea what to expect and in Canada, the majority of GAC programs are not following them into adulthood. So the sloppy approach to delivering this care will come back to bite us all, I am sure. Even in Canada we are seeing a rising political right-leaning reaction to these inadequate approaches to a significant intervention. We have a choice. Either we do a better job at the health care level or we put ourselves at risk of having politics make these decisions for us. That is the most terrifying to envision.

██████████ Your response seems to conflate informed consent discussions and gender assessments as a requirement for care. The article is about gender assessments as a requirement for care.

As for not using a Cochrane review, it would have been completely pointless because there are virtually no studies that actually bear on gender assessments' role in preventing regret and would meet rigorous inclusion criteria.

...  
[Read more](#)

██████████ As a transgender man, I tend to agree with the move toward informed consent. In my own experiences, I never had any difficulties with care providers who provided gender affirming care on an informed consent basis. I faced enormous difficulties (trauma, unwanted surgical results, additional surgery) after receiving care from a provider who relied on the SOC.

The rigidity of the SOC vs informed consent puts a fear in patients that they will be turned away from the care they know they need because of the least irregularity in their narrative or their desired outcome. It's getting better, but there have been times when people would practice for their appointments with friends to avoid saying the wrong thing. A system based on informed consent would eliminate these situations and fears.

The ability to speak freely with one's providers is more readily assured under informed consent than in a system with rigid gatekeeping. It is incredibly important to be able to communicate openly without fear of losing access to care.

We look back at the times when trans people had to pretend to be straight to receive care, for instance, and consider that abhorrent at best and a violation of their basic human rights at worst. Someday, the gatekeeping that is considered normal now may look very much much the same.

The sooner this is identified, the better.

 Comment

i) A WPATH member discusses certain European providers' hesitancy about starting hormone treatments in younger students

The screenshot shows a forum post on the WPATH website. At the top, there is a redacted header. Below it, the word "DISCUSSION" is visible. The main title of the post is "European guidelines for trans adolescents", followed by another redacted line. The post is part of a group titled "Non-Surgical Transgender Healthcare (969 members)". It has 3,671 discussion views and 11 responses. The author, whose name is redacted, writes: "I work at a college health center and working with my clinic to start offering gender affirming hormone therapy. We had a meeting of providers, and there was hesitancy about starting hormone treatments in younger students (though almost all students we see are 18+), based off of the guidelines from Finland and Sweden that recommended psychotherapy rather than hormone therapy for adolescents." They include a link to a City Journal article: <https://www.city-journal.org/article/yes-europe-is-restricting-gender-affirming-care> (https://www.city-journal.org/article/yes-europe-is-restricting-gender-affirming-care). The author asks, "I am curious if others have run into similar hesitation and how they have responded." and thanks the readers. There are options to "Add bookmark" and "Invite". Below the post is a "Submit" button. A second redacted header is visible below the post. A comment from a user with a redacted name begins with "Hi" and mentions a presentation in early June. The comment text is partially redacted but includes: "At [redacted] don't start hormones for students under age 18, although I have to say I haven't had any requests for that. With parental consent I would feel very comfortable doing this for a student over age 16. We have started a Collegiate GAC [redacted] or (and restricted to) providers of GAC in college health where we share information..." There are "Read more" and "Comment" options at the bottom.

[REDACTED]  
Thanks so much for your response, and I would love to learn more about your presentation or participate in the Listserv if possible, thanks!

[REDACTED]  
I'd also love this information. How can we access the presentation and/or list serve?

[REDACTED]  
May be worth noting that City Journal is run by the far-right Manhattan Institute and that the article's author Leor Sapir is known for his, um, 'loose' relationship with the truth.

In terms of response, it may be worth pointing to them that these European guidelines are based on the notion that trans care is based in 'low quality evidence', which is misleading given that 'low quality' is a technical term under GRADE and can still very much ground strong recommendations of care (see notably <https://www.tandfonline.com/doi/full/10.1080/26895269.2023.22183...>)

Read more

Comment

[REDACTED]  
In terms of Europe specifically, there's also this article that points out how misinformation around trans care often relies on a mythology of Europe as progressive that doesn't really pan out:  
<https://www.thestranger.com/queer/2023/04/06/78936831/the-gops-war-on-trans-kids-relies-on-myths-about-a-progressive-europe>  
(<https://www.thestranger.com/queer/2023/04/06/78936831/the-gops-war-on-trans-kids-relies-on-myths-about-a-progressive-europe>)



Eli Coleman PhD, LP

[REDACTED]  
While there may be some hesitancy, there is a misreading of the Swedish guidelines. The media is not the best source. They certainly have not stopped providing hormone treatment and they are more in line with SOC 8 than many people think. Despite legislation in US restricting access to medically necessary care, we are seeing these laws challenged as unconstitutional and not in keeping with the science. SOC 8 are the most up-to-date thoroughly researched guidelines. Adults and youth have a right to the best available care.

Comment

[REDACTED]  
Sure, here in Mexico have seen that the Psychological state improves after the GAHT in Teenagers (14-18) and the risk for depression and anxiety diminished around 60% if they begin hormones vs teens that didn't.


Remember that guidelines are just that Guides not bibles and the decision is made based on the circumstances of each case and patient.

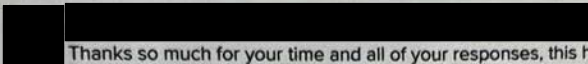
Comment


[REDACTED]  
This is a very dangerous development in the medical care of trans children and adolescents. I find the political interference in medical issues extremely questionable. We in Switzerland are also aware of

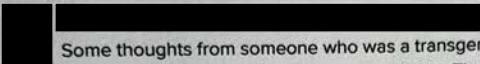
the efforts in the UK, Sweden and Finland. On closer inspection, however, the picture is more complex and one cannot speak of a total ban on puberty blockers or hormone therapy under the age of 18. But I'm sure my colleagues from these countries can comment on that. I would like to note here that not all of "Europe" shares this opinion of the Scandinavian countries. The German guideline and also the Swiss recommendations clearly implement the demands and...

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 Comment


 Thanks so much for your time and all of your responses, this has been really helpful and I've shared the links you all provided with the provider team at my clinic :)


 Comment

 Some thoughts from someone who was a transgender adolescent before there were gender programs available. There is a crush of bad media calling into question gender-affirming care, especially GNRh agonists, and gender-affirming hormone therapy. The first point is that when someone identifies themselves as transgender, there should be not only a thorough psychological assessment, but a sociological assessment, and primary care assessment. Once done, the counseling should be ongoing.

A magic question to ask your staff is how they view the idea of...

[Read more](#)


 Comment

 **Christina Richards** DCPsych, MSc, CPsychol, EuroPsy, FBP&S

Hello  
Gender care is, of course, vital for TGD youth and it is appalling that it is being limited.

Just a gentle reminder though, that the continent of Europe is vast - much bigger than the USA - and has over twice the population. It is a group of countries, so there is comparatively little that can be said of transgender healthcare in "Europe" as such. Some parts are having challenges, in some it is abhorrent (Hungary for example), in some it is benign, and in some progressing. For example Spain is making legal...

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 Comment

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