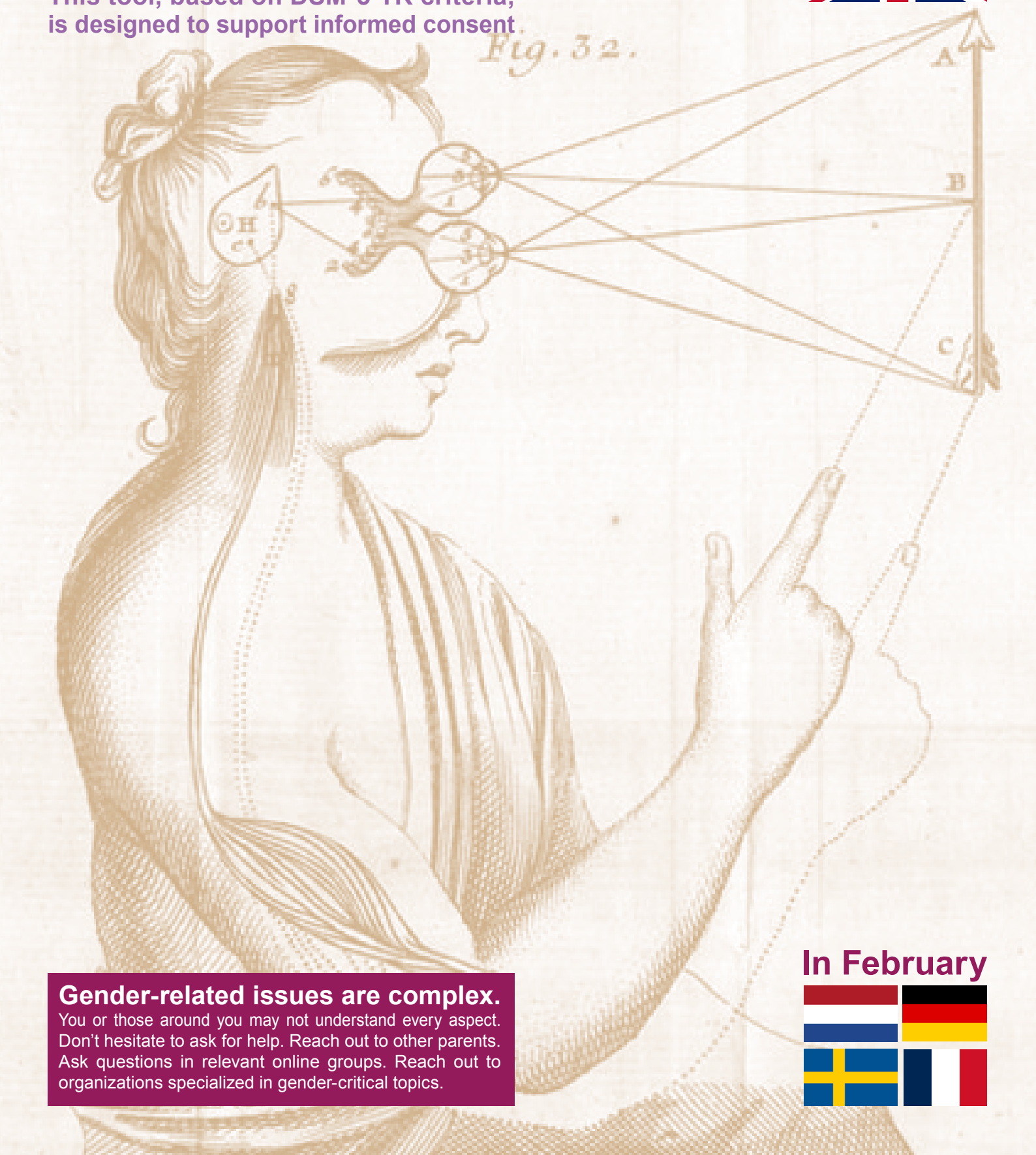
Genspect

Gender Dysphoria Support Tool:
Family and Friends Survey
Parental Survey

This tool, based on DSM-5-TR criteria, is designed to support informed consent.

January
2025



Gender-related issues are complex.
You or those around you may not understand every aspect. Don't hesitate to ask for help. Reach out to other parents. Ask questions in relevant online groups. Reach out to organizations specialized in gender-critical topics.

In February

Dear Parents,

We consistently receive desperate messages from parents whose voices have been ignored during their child's gender clinic assessments. Despite being invited to participate in the diagnostic process, their crucial insights are routinely dismissed in favor of immediate affirmation.

***The current system is deeply troubling:** while clinics may request parental input, a child's self-declaration typically overrides years of family knowledge and observation. These consultations have become little more than administrative formalities – checkboxes for insurance paperwork rather than meaningful clinical investigation.*

*This practice fundamentally undermines sound healthcare. **Parents and family members hold vital knowledge that brief clinical encounters cannot capture.** A meta-analytical review of Dowell and Ogles (2010)[1] and a meta-analysis of Sun et al. (2019)[2] demonstrated that involving parents in their children's treatment provided an added benefit to the overall effectiveness of the treatment. Parents understand their child's patterns, their struggles, their personality shifts. They're often first to notice underlying issues that might be contributing to their distress. Yet these essential insights are frequently set aside.*

Gender-related distress emerges through many pathways, which means there are equally many routes toward resolution. When clinics automatically prioritize a young person's self-report, they miss opportunities to explore more appropriate, less invasive approaches to alleviating distress.

To help families advocate for thorough, evidence-based care, we have developed two complementary tools:
***1. The Family and Friends Survey** - This assessment gathers observations from family members and others who have known your child well over time. When multiple observers share similar perspectives, their collective insight becomes harder to dismiss.*
***2. The Parental Survey** - This detailed questionnaire helps identify underlying factors that warrant investigation before any irreversible interventions are considered.*

*We recommend completing this survey whether or not the family members currently support immediate transition. Together, these surveys provide a comprehensive picture that can help ensure your child receives the careful, thorough assessment they deserve – one that explores all contributing factors rather than rushing toward medicalization. When a number of surveys have been completed by family members, we recommend that you print them out and physically hand them to your child's clinician. We also recommend that you send electronic copies of same and save them for future references. This ensures that the clinician cannot so easily dismiss the family's views – they are now on file, and they can be referred to in the future should they be required. **We also recommend sending the completed survey to your primary care doctor and insurance company** to ensure that all parties involved are informed about the range of issues associated with medical transition.*

The survey also offers an added benefit as it offers an opportunity for the extended family to engage with this issue in a more thoughtful manner and it invites them to stay or become a helpful presence in your vulnerable child's life. Worried parents tend to avoid the issue of gender however this is not always a helpful approach. Ignoring the elephant in the room is a common response to mental health issues in the family, but it is not as helpful as it initially seems to be. While the parent and the young person successfully avoid fights about trans issues, the young person is typically nurturing a carefully created persona that can impede the child's opportunity to recover.

*Remember: **questioning the current approach isn't about rejection.** It's about ensuring young people receive appropriate care that first does no harm. Your knowledge of your child matters, and these tools will help you advocate effectively for thoughtful, comprehensive assessment.*

By working together and using these tools, you can ensure your voice is not only heard but put on file. Your insights are invaluable, and advocating for thorough, evidence-based care is essential for your child's path forward.

Best wishes,
Stella O'Malley/Genspect
2025

1 Dowell K. A., Ogles B. M. (2010) **The Effects of Parent Participation on Child Psychotherapy Outcome: A Meta-analytic Review.** https://www.tandfonline.com/doi/abs/10.1080/15374410903532585
2 Sun M., Rith-Najarian L. R., Williamson T. J., Chorpita B. F. (2019) **Treatment Features Associated with Youth Cognitive Behavioral Therapy Follow-up Effects for Internalizing Disorders: a Meta-analysis.** https://pubmed.ncbi.nlm.nih.gov/29677451/

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Panic in the Family

Your child has informed you that they are questioning their gender and are attending a gender clinic at the hospital. How do you respond to this situation with the hospital? Many families are caught off guard by this issue, leading to years of emotional turmoil and discussions, often with increasing pressure. The person's self-reported identity may not be immediately recognized by family members, and even when it is, there is often reasonable concern about pursuing irreversible medical interventions.

Understanding Self-Reported Identity

The core challenge in clinical assessment is that experienced gender identity is not physically measurable. Healthcare decisions must be based on objective evidence rather than subjective experience alone. To quantify observable patterns, we have designed a survey not only for immediate family members, but also for the broader circle of people who know the person well, preferably from birth: friends, neighbors, teachers. The survey follows the criteria described in the DSM-5-TR.
Clinicians often dismiss parental observations with the explanation that the child did not feel safe expressing themselves to their parents. While this may be true in certain cases, particularly in strongly conservative or religious families, it becomes less credible if no one in the extended family or social circle ever noticed any signs. A cousin, childhood friend, neighbor, teacher, aunt, or grandparent - someone would likely have observed something over the years. **If no one has ever noticed anything, the story simply does not add up.**

The Gender-Affirmative Model

A fundamental principle in the gender-affirmative model is that the person's self-experience is paramount in the care process. This presents a concerning problem: not only is the person's desire paramount, but their self-diagnosis also plays a decisive role in the diagnostics performed by clinical psychologists or psychiatrists.
When discussing these concerns with friends and acquaintances, it can quickly lead to debate. A common defense is that the care provided is very good and consists of highly skilled experts. Parents or partners who question this process are often dismissed as overly suspicious or lacking understanding. Hospitals communicate to the press that they conduct very thorough diagnostics before making significant steps.

How Does a Diagnosis Proceed?

From experience, we now know that the diagnostic process works differently than portrayed. The hospital diagnoses via a method based entirely on the person's self-reference. We will describe the procedure in the Dutch clinics, as it is assumed other countries follow a similar approach. Once a person is seen by a healthcare provider, a survey follows. The person must then write a letter explaining their feelings. The letter confirms the survey, and vice versa. These documents are considered evidence of 'gender incongruence'. The letter and the survey originate from the same source and amplify each other, though they stem from a single origin. **A frequently mentioned additional issue is that the person clearly relies on a learned script.** The clichéd language suggests that the ideas do not come from personal experience but are instead imposed or instilled.
Gender incongruence is not the same as gender dysphoria, although they are sometimes used interchangeably. This can be very confusing. Gender incongruence refers to a disconnect between experienced gender and biological sex, while gender dysphoria describes clinically significant distress associated with this disconnect. This is a significant difference. **It remains puzzling why insurance companies would cover a care process based on incongruence alone, without documented distress.**

Current Clinical Practice

In the Netherlands, in general comprehensive differential analyses are not conducted. While clinics investigate whether a person has psychosis, autism, narcissism, or other mental disorders, these co-existing conditions are noted and considered in the care process, but not to inform the 'gender incongruence' diagnosis. The question becomes simply: Is the person fit enough? This is not a differential approach, but more like **an assessment of readiness for intervention**.
There is rarely rejection based on trauma history, bullying experiences, autism, or other mental health conditions, with insurance covering the process (except for a small co-payment). **In the Netherlands even persons with intellectual disabilities receive gender-affirmative care**.[3]
Insurance companies trust that the care provided is adequate. The survey and motivation letter appear thoroughly on paper. However, this perception was challenged when Dutch parents emerged with a rigorous systematic intervention in the form of a family survey that revealed something entirely different and exposed the limitations of self-diagnosis. This survey is based on their approach, and this gives you as a concerned parent significant input into the process.

Impression of the Environment

The gender teams claim to be committed to family harmony. Because the care dossier must give the impression that a broad perspective is being considered, there is active encouragement for discussions with parents, partners, and other directly involved parties.
Those familiar with gender-critical literature, such as the books by Abigail Shrier and Hannah Barnes and the testimonies of whistleblower Jamie Reed, know that the reality is more complex: Parents are formally invited to share their perspective. The care worker often nods politely, notes down the family's impressions, and reassuringly says they understand. While many parents disagree with their child's self-diagnosis, some may go along with their child's thoughts, but others remain critical.
However, in follow-up conversations, although the family's concerns are acknowledged, the diagnosis is still considered established, and the treatment process typically continues as planned. The family's impressions are noted but rarely affect the final decision. In fact, their concerns may be used to make the research appear more thorough on paper to satisfy insurance requirements.
Parents who give their consent despite reservations often realize the implications only later. A notable example of this dynamic was revealed in Elon Musk's interview with Jordan Peterson in July 2024.[4]

3 **Genderpoli / They and Them (Nov 2023)** Dutch documentary https://www.npodoc.nl/documentaires/2023/11/genderpoli-they-and-them.html
4 **Elon Musk Interviewed by Jordan Peterson (July 2024)** https://www.youtube.com/watch?v=Q20Nbq3EJsc

Purpose of The Family and Friends Survey

Drawing from the significant findings of Shrier, Barnes, and Reed, among other concerning clinical reports, we have developed an assessment method that extends beyond parental input to include broader family observations.
The survey, based on DSM-5-TR criteria for Gender Dysphoria, is designed for adults who have known the person for an extended period and have detailed knowledge of their development. This includes family members, neighbors, cousins, childhood friends, former schoolteachers, and work supervisors. Through this comprehensive approach, we aim to support clinicians and families in making well-informed, evidence-based decisions.

Systematic Documentation and Clinical Validation

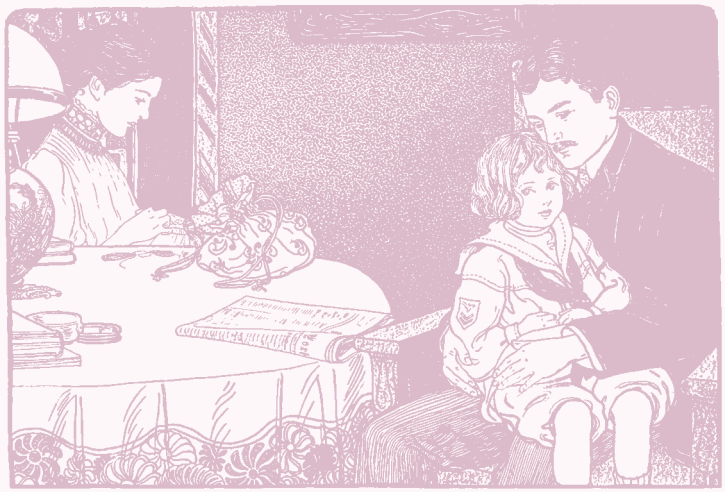
The survey's primary value lies in its ability to objectify parental observations. While people may report that their gender incongruence was always present but concealed, or that parental resistance stems from conservative views, these claims require careful clinical evaluation.
Abigail Shrier's research demonstrates that families seeking thorough assessment are typically open-minded, accepting of sexual orientation diversity, politically progressive, well-educated professionals who possess significant insight into their children's development.
Survey results consistently show that extended family members and acquaintances often share similar observations to parents. It is clinically significant when multiple observers across different contexts report no prior signs of gender incongruence. Early developmental patterns typically manifest in observable ways to at least some members of a child's social network. **Therefore, this systematic documentation represents a crucial clinical tool that warrants serious consideration.**

Gender-Critical Perspectives Are Not Far-Right Politics

It is important to note that Shrier, Barnes, and especially Reed (the latter being a lesbian healthcare professional married to a transgender individual at the time of her whistleblowing) are **progressive intellectuals**. This demonstrates that critical analysis of current protocols comes from varied intellectual backgrounds, not any particular ideological position.

Impact on Diagnosis

The results of the survey provide the specialist with insight into how the entire family perceives the person and give more weight to the aspect of family issues in cases of differing opinions. Official guidelines for transgender care offer little information on family issues,. Yet **dismissing family dynamics when considering irreversible medical interventions raises serious ethical concerns.**
If there is a social gap, relationship therapy should first take place. **Disrupting the family through a care process that involves high levels of family friction raises serious ethical concerns regarding patient care and family wellbeing.**



Parent of 21-Year-Old Gay Son

"I have a 21 year old gay son who believed he was a girl from age 14-19. Every doctor I spoke with told me to take him to the gender center at CHLA (Children's Hospital Los Angeles). When I called CHLA, I spoke with the social worker of the pediatric gender department and told her about my son. ***After a 5-minute phone call she told me I should get my son on puberty blockers, without ever meeting him.*** *We never went. I also had an encounter with my primary care doctor who dismissed my concern when I told her about my son.* ***The only thing she told me was to take him to an endocrinologist, and she refused to consider other options for why he felt he was female.*** *Thank God I never listened to these doctors but listened to my common sense. It was a tough 5 years, but he grew out of it and realized he was just gay. Where would he be now if we had taken their advice? Still infuriates me!"*

Clinical Considerations Regarding Co-Existing Conditions

Due to the growing clinical discussion surrounding the gender-affirmative model and emerging research evidence, we have developed this assessment tool to help clinicians thoroughly evaluate potential co-existing conditions. When a young person has experienced trauma, exhibits self-directed negative emotions, or has a neurodevelopmental condition like autism, careful consideration must be given to how these factors may influence their self-reported gender incongruence. This thorough evaluation is essential before considering any irreversible medical or surgical interventions, following medicine's fundamental principle: **First do no harm.**

Diagnostic Overshadowing

The **Cass Review** highlights the phenomenon of **'diagnostic overshadowing'** (misattributing symptoms to an condition) within gender-affirming care, relating to adaptive coping mechanisms. Persons may attribute their distress to recently recognized conditions rather than identifying and addressing underlying factors. This pattern has been observed in various contexts, including conditions such as RSI (repetitive strain injury), false memory syndrome, and dissociative identity disorder. These conditions often share characteristics of being difficult to measure objectively and relying primarily on reported experience. While the distress is genuine, potential nocebo effects warrant consideration.

Given that gender-affirming treatments often involve irreversible medical interventions, the implications of diagnostic overshadowing are significant. Recent data suggesting a 30% loss to follow-up rate[5] raises important clinical questions. Therefore, thorough documentation and comprehensive evaluation are essential before proceeding with medical intervention.

SOC-8 and the Dutch Protocol conflict with the Cass Review

Shortly after the publication of the Cass Review, a statement was issued by Dutch clinics claiming that the practices described in the report were already common practice in the Netherlands. **This is untrue.** The original Dutch protocol was based on **patients who had shown clear gender-nonconforming behavior from a young age** and expressed a desire to be of the opposite sex. Additionally, a strict condition was that the children had **no other issues,** and that **family support** was present.

The so-called **'real-life test'** was also part of the protocol. This was a two-year phase during which individuals were required to live as the opposite sex. This allowed them to experience the practical consequences of their transition and demonstrate to the clinic that their desire was genuine and well-considered. This procedure was discontinued in 2014. Today, individuals diagnosed with gender dysphoria—based completely on their own self-assessment—can begin hormone therapy immediately after receiving a formal diagnosis. While this approach increases accessibility, it can lead to challenges, such as unmet expectations or unforeseen issues that may not have been apparent before the transition.

The practice in the Netherlands, as well as in any other country following WPATH's Soc-8 model, aligns with what is described in Barnes' book and precisely represents the core of the criticism Cass raises in her report.

Impact on Family Systems

The absence of evidence-based explanations creates significant challenges for families. Parents often experience severe stress during this process, and inadequate clinical communication can compound family distress. When clinics fail to address family concerns or provide clear clinical rationales, **they risk causing iatrogenic harm to the family system.**

Survey Implementation

The parental survey contains a comprehensive list of common co-existing conditions. Parents should indicate which conditions they have observed. When submitting this to the clinic, **request explicit feedback on**:

- Whether clinicians have observed similar patterns
- If not, the clinical basis for different observations
- How identified conditions may influence the self-reported gender incongruence
- The proposed mechanism of interaction between conditions

Clinical Responsibility and Family Rights

While respecting patient privacy, open communication remains essential given the implications of irreversible medical interventions and their impact on long-term health outcomes. Decisions affect the entire family unit and may cause significant stress-related health risks. Therefore, **families have a right to receive sufficient information** to understand and process clinical decisions.

When clinics decline to address these concerns, they risk causing iatrogenic harm not only to the patient but to the family system. **Healthcare providers must maintain ethical standards that consider both individual and family wellbeing.**

Parent of Daughter with Multiple Co-Existing Conditions

*"Our young adult daughter, who fell into a non-binary identity due to **peer contagion and online influence** while in high school, had her head set on having her breasts removed to prove that she was 'transmasc'. Despite of a letter denoting **her co-morbid mental health conditions, including disordered eating, autism, trauma from bullying, and OCD,** our medical provider removed our daughter's healthy breasts. The medical organization never contacted us to discuss our daughter's mental health issues. We have some bad therapists to thank for enabling and capitulating in this self-loathing and self-harming behavior."*

5 H. Postma (Oct 2024) **The Dutch Leaks: Trans Regret is Possibly 33%** https://genspect.org/trans-regret-is-possibly-33/

Characteristics According to DSM-5-TR

The DSM-5-TR lists two sets of criteria for recognizing 'gender dysphoria' (GD), early and late onset.[6]

Early Onset Gender Dysphoria (EOGD)

Children are typically diagnosed with gender dysphoria if they have experienced **significant distress** for at least six months and at least **six of the following:**

- Strong desire to be of the other gender or an insistence that they are the other gender
- Strong preference for wearing clothes typical of the opposite gender
- Strong preference for cross-gender roles in make-believe play or fantasy play
- Strong preference for the toys, games or activities stereotypically used or engaged in by the other gender
- Strong preference for playmates of the other gender
- Strong rejection of toys, games and activities typical of their assigned gender
- Strong dislike of their sexual anatomy
- Strong desire for the physical sex characteristics that match their experienced gender

Late Onset Gender Dysphoria (LOGD)

To be diagnosed with gender dysphoria as a teenager or adult, you must have experienced **significant distress** for at least six months due to at least **two of the following:**

- Marked incongruence between your experienced and expressed gender and your primary or secondary sex characteristics
- Strong desire to be rid of your primary or secondary sex characteristics
- Strong desire for the primary or secondary sex characteristics of the other gender
- Strong desire to be of the other gender
- Strong desire to be treated as the other gender
- Strong conviction that you have the typical feelings and reactions of the other gender

Parent of Teen Daughter Who Desisted

*"From the age of 11 to 15 my daughter struggled with anxiety, PTSD, and possible ADHD. She learned about the idea of 'transgender' **from being online too much, counselors discussing the concept with her without our knowledge, and peers at school**. It's been incredibly disappointing and disorienting to realize that every professional I trusted to help guide our daughter toward a more holistic understanding of herself focused only on gender identity. Our concerns that our daughter's distress was a maladaptive coping mechanism, and that she was being influenced by a social contagion were dismissed. Her private counselor deemed us '**unaccepting parents**'. The school counselor encouraged 'identity exploration' and supported the idea that my daughter 'may really be a boy', changing her name and pronouns at school. After she became sullen and withdrawn, I realized, that at 14, our daughter was secretly speaking to a trans-identified Licensed Clinical Social Worker about medicalizing 'her gender' with hormone shots and surgeries. All of this was done without my knowledge or consent. Shockingly, even being aware of all the issues our daughter was dealing with, our pediatrician promoted the 'options' of puberty blockers and binders. **These adults all put their blind trust in a child**, discounting the process of identity development and without realizing that my daughter's focus on gender identity was perpetuated by them speaking to her about this as a real possibility. My daughter ended up desisting right before age 16 and is now so grateful that I did not give in to her continuous demands to see her as the opposite sex and allow medical interventions. **My family will live with the fallout, trauma, and anger of this experience for the rest of our lives, and truly believe ourselves to be victims of a terrible medical ethics scandal.**"*

6 **DSM-V-TR online:** https://archive.org/details/dsm-5-tr/page/n1/mode/2up

The Illogic of the DSM-5-TR Criteria for 'Gender Dysphoria'

Show to Family and Friends

Feminism and Gender Roles and Expression

Feminism rightly critiques the stereotyping of gender roles. After all, everyone should be free to express themselves without being constrained by social norms like "girls play with dolls" or "boys must be tough." A person exhibits certain behaviors because they find them comfortable or interesting. **This should remain free from speculation about a supposed 'gender identity.'**

The DSM-5-TR and Regressive Gender Stereotyping

However, the DSM-5-TR criteria use the vaguely defined term 'gender expression' and gender roles as indicators of experienced gender dysphoria. For instance, a boy with a strong preference for 'girls' toys' or feminine behavior may meet the criteria for gender dysphoria. **This approach represents a regressive fallback to stereotypes** and conflicts with the feminist notion that behavior is independent of sex. Feminism rightly emphasizes that breaking sex stereotypes is not an indication of a so-called 'gender incongruence' and should have no medical or diagnostic significance.

Context of 'Gender Dysphoria'

The DSM-5-TR attempts to identify 'gender dysphoria' in individuals who express psychological distress over an experienced incongruence between their 'gender identity' (based on regressive stereotypes) and their biological sex. It is not purely about behavior, but about behavior combined with significant discomfort. Using sex stereotypes as diagnostic markers is problematic, as it may lead to **unnecessary pathologization** of individuals who simply do not conform to traditional gender roles.

Homosexual individuals, artistic people, those with autistic traits, or those with mental health conditions often display atypical behavior. The individual's self-conclusion should be examined. Why does the person come to believe they are of the opposite sex or not having a sex at all (non-binary), when this is a biological impossibility?

A better solution is to make diagnostics independent of stereotypes and focus more on the emotional and psychological experiences of the individual. Freedom in 'gender expression' makes trans-medicalization unnecessary. Why harm a body when a person can simply express themselves in any way they wish?

What Does the DSM-5-TR Analyze?

The DSM-5-TR criteria analyze whether a person behaves in a gender conforming or non-conforming manner based on regressive stereotypes. **This is fundamentally flawed.** However, if an individual clearly behaves in a gender conforming way according to their environment, this should be a significant red flag for the clinic, and no trans-medicalization should occur. The DSM-5-TR criteria explicitly require non-conforming gender expression, which is notably absent in this group.

If there is non-conforming behavior, **this is still not a legitimate reason for trans-medicalization**. Atypical behavior can occur for entirely different reasons, which cannot be differentiated through the overly simplistic and flawed DSM-5-TR criteria. The clinic must demonstrate how it has differentiated, though it is expected they cannot do so, as no methods exist to measure this. **"First, do no harm" takes precedence over medicalizing the indeterminate.**

Is the Family Survey Then Unnecessary?

No. It often happens that family and friends, out of compassion, support the individual's narrative. Part 1 of the survey, which is based on the DSM-5-TR, prompts friends and family to reflect on how incoherent the diagnostic criteria actually are and that these should never serve as the basis for agreeing to drastic, body-damaging trans-medicalization. The subsequent parts of the survey provide the clinic with additional insights into what is happening with the individual.

Characteristics of Rapid-Onset Gender Dysphoria (ROGD)

ROGD, of Rapid-Onset Gender Dysphoria, is a hypothesis by Dr. Lisa Littman that describes **the sudden emergence of gender-related distress,** particularly in adolescents and young adults without prior signs in childhood.[7]

The ROGD hypothesis suggests that gender-related distress may be influenced by social and environmental factors, including:

- Social isolation (e.g., during COVID-19 pandemic)
- Internet influence (due to increased online engagement)
- Underlying anxiety
- Misinterpretation of other mental health issues
- Peer group dynamics

The Survey as an ROGD Indicator

An unexpected finding emerged during survey development: The tool confirms the likelihood of the ROGD hypothesis. Littmans observation has generated significant clinical discussion as it presents an alternative to the gender-affirmative model, which typically characterizes gender identity claims as innate and unchangeable. A common critique of Littman's research - that it relied on parent interviews rather than direct patient reports - overlooks important methodological considerations regarding self-reporting bias in clinical assessment. **The Family and Friends Survey helps objectify parental observations,** providing systematic documentation of when and how gender-related distress emerged.

The Shifting Scientific Consensus

A fast-growing group of experts, including **Hilary Cass, Jonathan Haidt, Gordon Guyatt (EBM), Richard Dawkins, Ray Blanchard, Stephen Levine, Michael Bailey, Ken Zucker, Marcus Evans, Michael Biggs, Riittakerttu Kaltiala** and many other prominent researchers, support Littman's analysis. Due to these experts' academic credentials, ROGD deserves to be taken more seriously than gender clinics would have us believe. Their perspective no longer aligns with the increasing awareness in 2025 that **social contagion** likely plays a significant role in the extreme rise in cases.

Important to Realize

The existence of ROGD is often ignored by Gender Affirming Care clinics, since it is directly in conflict with providing medicine and surgery, since **this type of gender distress is not innate**, but socially induced. The clinics suffer from a financial conflict of interest and a sunk cost fallacy. Admitting they were wrong will cost them money and may even lead to punishable repercussions. Denying ROGD however is unsustainable. The clinic must prove why a person doesn't have ROGD. We as parents don't have to prove ROGD exists. **That is a reversal of the burden of proof imposed on parents** who are not specialists and **don't have the resources to set up a study.**

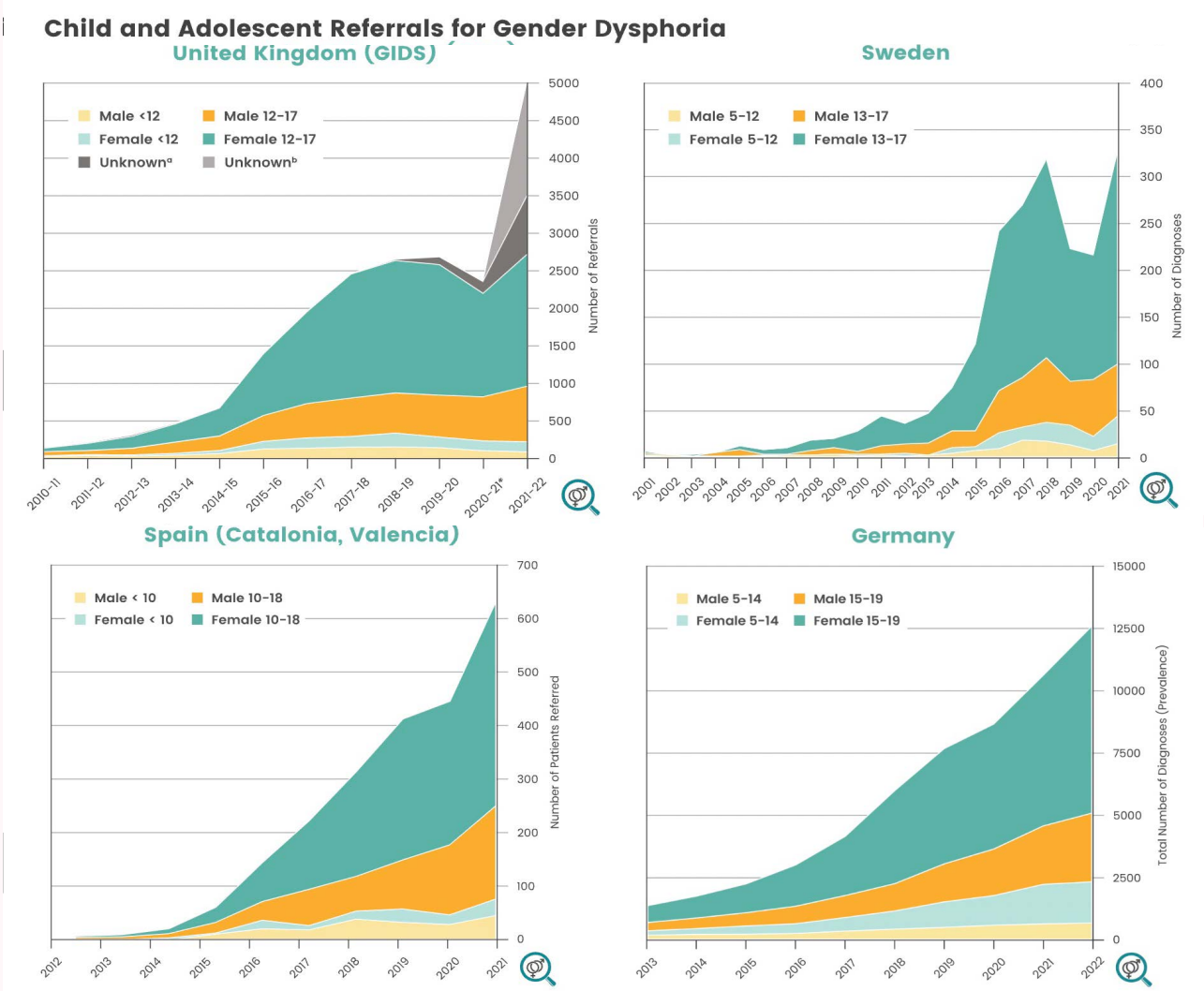
Parent of 23-Year-Old Daughter Who Desisted

"As soon as I told our family doctor that my 23-year-old daughter identified as transgender, she immediately gave a referral to the gender clinic at the medical center on my daughter's university campus. I did not think that affirming my daughter was the right course of action. I wanted to have a conversation with the doctor about the phenomenon of ***Rapid-Onset Gender Dysphoria****, which accurately described my daughter's experience. The doctor would not listen to me.* ***When I tried to give her a printed article about ROGD she put her hands in the air and refused to take it.*** *She told me that she has many transgender patients and already knew enough. I lost confidence and trust in that doctor, and never went back. My daughter has since desisted. I'm still upset with that doctor for disregarding me, and very relieved that we did not follow her ill-informed and misguided advice."*

7 Lisa Littman (2018) **Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria**
https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0202330

Epidemic

After the term 'Gender Identity Disorder' was replaced with 'Gender Dysphoria' in the DSM in 2014, and media coverage of transgender youth increased significantly, the number of referrals to gender clinics in all Western countries **rose by 2000% to 5000%.**



Wertherism

Wertherism, a term derived from Goethe's novel *The Sorrows of Young Werther* (1774), refers to the phenomenon in which people are influenced by media or stories, **particularly in the realm of self-destructive behavior.** In the book, the protagonist Werther dies by suicide with a pistol after his love for an unattainable woman remains unrequited. Following the novel's publication, there was an increase in young men who died by suicide in a similar manner, sometimes even dressing in the same style as Werther.

In other words, a collective, absolute belief emerged that happiness could only be achieved through **True Love; without that prospect, suicide seemed the only way out.** This phenomenon led to the term "Werther Effect," which describes the risk of imitation behavior following the public reporting of suicides.

Detransitioner Charlie Bentley-Astor *(interviewed by Andrew Gold)*

"Queer Destiny is essentially this rather pernicious idea that if you are born gay or bi or trans or queer, whatever label you decided that you are that is the most important thing about you. It's the defining feature of your existence and governs the trajectory of your life. You can either go with it or you can kill yourself because that's the only two choices. Because if you don't let it be, it festers, and you're so trapped within yourself and it's so hideous that your only escape is to kill yourself. But that is just an idea."

Detransitioner Christina Hineman

"Kind of like a punk thing, but rather than sex, drugs, and rock and roll, it was just drugs. And surgery. It's a medicalized version of normal teen rebellion. And I got completely sucked into that."

Mia Hughes *- Author of the 'WPATH Files'*

"Rapid-onset gender dysphoria is the most obvious social contagion ever to have occurred."

13 Untruths Behind Gender Affirmative Therapies - *by Dr. Stephen Levine*

On Feb 21, 2023 the **Florida House Health & Human Services Committee** heard testimony from licensed psychiatrist **Stephen Levine MD.** He outlined 13 scientifically false assumptions which serve as the foundation of affirmation-only therapy for gender dysphoria in kids.[8]

"I have found 13 ideas in the literature written by those who advocate care for children, adolescents, and adults dealing with the transgender phenomenon. Each of these 13 points, in my view, is scientifically untrue. Nonetheless, they are firmly believed, and when challenged or discussed in meetings, they provoke passionate outrage at the suggestion they are false. However, as far as I can see, these 13 ideas are neither scientifically verifiable nor clinically accurate. Yet they are repeatedly affirmed in the writings and speeches of doctors who support affirmative care.
Before I present these 13 points, I want to offer another perspective on this major question about transgender care for youth: Is this an example of therapeutic progress to help affected individuals, ***or is it yet another medical misstep?***
In medicine, we have a history of many missteps. The most recent and among the most damaging is the opioid crisis. We began prescribing opioids liberally without scientific evidence of their utility and harm. Now, in every state in the United States—and elsewhere—people are suffering premature deaths due to opioid abuse.

Here are the 13 things that, in my view, are not true:
1. 'A trans identity, once established, is immutable, unchangeable, and unchanging.' This is clearly not true.

2. 'Trans identities are primarily caused by prenatal biological forces.' This claim suggests that treatment is merely correcting some biological or embryological mistake.

3. 'Sexual orientation is entirely independent of gender identity.' Sexual orientation is a bias for romantic and sexual purposes toward members of a certain class (males or females). However, as children develop—from childhood to puberty and through adolescence—gender dysphoria often manifests alongside same-sex attraction, indicating that they are not entirely separate phenomena.

4. 'No form of gender identity is an abnormality, nor is it a symptomatic reflection of some other problem.' This is not a psychologically tenable concept, yet it is asserted frequently in the literature.

5. 'Gender dysphoria is a serious medical condition that requires medical intervention, but only if the patient wants it.' This idea contains an inherent paradox: if it is a serious medical condition, it implies the necessity of treatment, but only if the patient desires it.

6. 'The associated emotional problems are primarily due to living in a discriminatory world.' Many children diagnosed with gender dysphoria were previously diagnosed with other psychological conditions.

7. 'No effective alternative approaches to affirmative care exist.' Practitioners often claim this is the only solution for children, but alternative psychiatric approaches, like those discussed by Dr. Laidlaw, do exist.

8. 'Attempts to provide psychotherapy are unethical versions of conversion therapy and should be outlawed.' Any attempt to help the child and family is often labeled as conversion therapy, with calls for it to be banned in various jurisdictions.

9. 'Affirmative care lastingly improves mental health and social function.' This justification lacks supporting long-term studies. In fact, data indicate elevated death rates among transsexual adults.

10. 'Affirmative care reduces suicidal ideation and prevents suicide.' This is a powerful, coercive narrative told to parents of teenagers. However, studies—such as those from Sweden—show significantly elevated suicide rates among adults who have undergone sex reassignment surgery.

11. 'Young teens know best what will make them happy in the future.' This claim assumes that a teen's "true self" is fully understood, which is not necessarily the case.

12. 'Meeting diagnostic criteria for gender dysphoria predicts a good outcome with affirmative care.' This is demonstrably false.

13. 'Regret and detransition are rare among these patients.' Recent years have shown that detransition is increasingly recognized. The narrow definitions of "regret" (e.g., informing the original therapist or requesting bodily changes back) limit a proper understanding of this phenomenon.

These 13 ideas underpin the assertions of affirmative care. If the ideas themselves are not true or scientifically supported, how can we trust the interventions based on them?"

As a supplement in line with Levine's enumeration:
The German version of this Genspect survey highlights, through a quote from the German critical thinker Alexander Korte, that every DSM diagnosis is **always a snapshot** and **should never be a reason for permanent, irreversible bodily modifications.**[39]

8 **Dr. Stephen Levine: 13 Untruths Behind Gender Affirmative Therapies for Kids** (Feb 2023) https://www.youtube.com/watch?v=OflbCjj_hVc
39 **Hinter dem Regenbogen, A. Korte, pagina 210** (2024) https://shop.kohlhammer.de/hinter-dem-regenbogen

Recommendations Worth Checking Out

The more you know, the better you can protect your child.

Books and Literature about Gender

- *End of Gender: Debunking the Myths About Sex and Identity in Our Society* - **Debra Soh** ISBN-13 978-1982132521 (2023). An essential critique on the flaws of gender studies as a science.
- *Irreversible Damage* - **Abigail Shrier** ISBN-13 978-1800750364 (2021). About ROGD.
- *Time to Think* - **Hannah Barnes** ISBN-13 978-1800751118 (2023). About Tavistock scandal and disturbing science and history of Gender Affirming Care as a false treatment model.
- *Trans* - **Helen Joyce** ISBN-13 978-0861543724 (2022). About the problems of Gender Ideology in the broadest sociological perspective.
- *Detrans* - **Dr. Az Hakeem** ISBN-13 979-8862184549 (2023). About the psychology of transvestic and transsexual behavior and its severe consequences on the persons themselves, but also on their social environment.
- *When Kids Say They're Trans* - **Lisa Marchiano, Stella O'Malley & Sasha Ayad** ISBN-13 978-1800752641 (2023). A Guide for Parents.
- *Lost in Trans Nation: A Child Psychiatrist's Guide Out of the Madness* - **Miriam Grossman** ISBN-13 978-1510777743 (2023). Central thesis: Parents know their child best.
- *The WPATH Files* - **Mia Hughes** (2024). Exposes the corruption of WPATH and how this affected all gender care around the world.
- *The Cass Review, Final Report* - **Hilary Cass** (2024). The scientific evidence of what Barnes already exposed in her book.

Books about the Broader Perspective

- *Bodies under Siege* - **Armando R. Favazza** ISBN-13 978-0801899669 (2011). About self-mutilation, nonsuicidal self-injury, and body modification in culture and psychiatry.
- *Crowds and Power* - **Elias Canetti** ISBN-13 978-0374518202 (1984). About collective behavior, mass manias, cults, extreme (self-harm) rituals.
- *The Rape of the Mind* - **Joost A. M. Meerloo** ISBN-13 978-1-61577-376-3 (2009). About the psychology of thought control, menticide, and brainwashing.

Not a Reader? No Problem!

- Check interviews on **YouTube** with the above-mentioned experts, watch **Gender: A Wider Lens Podcast**.
- Go on **X** (and other social media platforms) and follow gender critical organizations such as **Genspect, Stats for Gender, PITT, Parents of Desisters, Do No Harm, Therapy First, CAN-SG and many others**.
- Approach **parent groups** and **gender critical organizations.**
- Write **letters to the media and politicians** and ask for help.
- Visit **conferences** to get connected.

Eliza Mondegreen *- 3 days at the European Professional Association for Transgender Health Conference*[9]

"In a disturbing update on the 'intersection' of autism and transgender identity among patients at the Dutch clinic, researchers reported that—out of ***30 patients*** *potentially eligible to participate in a 17-year follow-up study—****four had declined to participate, two had detransitioned, one who had not detransitioned expressed serious regrets about vaginoplasty, and two had "passed away."*** *Only at the end of the presentation did the researchers admit that the two patients who had 'passed away' had in fact* ***died by suicide****. The deaths of these two patients—the researchers said—showed that there are 'two sides of the coin', that there's 'no crystal ball', and that the issue 'should not be dealt with without nuance'. What a 'nuanced' approach looks like, nobody bothered to specify. Is it possible that 'nuance' means glossing over negative outcomes so no one draws the wrong conclusions? The presenters preferred to dwell on the 'diversity' of their 'trans-autistic' patients, with their variety of self-identifications 17 years after they started down the path to transition: 'fairy', 'elf', 'non-binary', 'friendly non-intimidating woman', 'cis' (read: detransitioned). "Each referral," the presenters said, including the patients who died and the patients who detransitioned or experienced regret, "followed their own unique path with regard to their gender identity and mental health trajectory."*

Over and over again, researchers and clinicians presented damning findings that suggest something is going seriously wrong in the world of 'gender-affirming care' and then ***neglected to apply their findings to their work, which remains 'imperative' and 'life-saving' — even when patients die.****"*

9 Eliza Mondegreen (4th May 2023) **Part I: Three days at the European Professional Association for Transgender Health** https://genspect.org/dont-stop-believin-three-days-at-the-european-professional-association-for-transgender-health/

Genspect

Hand Over to Clinic

Family and Friends Survey

An Objectification of the Parental View

For Clinical Review Prior to Initiating Gender-Affirmative Interventions

Gender-related issues are complex. You or those around you may not understand every aspect. Don't hesitate to ask for help. Reach out to other parents. Ask questions in relevant online groups. Reach out to organizations specialized in gender-critical topics.

Family and Friends Survey - 1

Hand Over to Clinic

Sixteen Questions Based on DSM-5-TR Criteria

To develop this survey, we have rewritten the DSM-5-TR criteria into questions suitable for family members and acquaintances. We took two characteristics from the child section and applied them to the adolescent behavior (Q7 and 8).

Present

1. Is there a clear visible discrepancy between the expressed gender (gender expression) and the biological sex?
   0 Yes 0 No 0 Unclear

2. Does the person express a strong desire to get rid of their primary or secondary sex characteristics?
   0 Yes 0 No 0 Unclear

3. Does the person present themselves clearly as the opposite sex in their clothing and behavior?
   0 Yes 0 No 0 Unclear

4. Does the person strongly express a desire to become as the opposite sex?
   0 Yes 0 No 0 Unclear

5. Does the person strongly express a desire to be treated as the opposite sex?
   0 Yes 0 No 0 Unclear

6. Does the person display typical feelings and reactions normally associated with the opposite sex?
   0 Yes 0 No 0 Unclear

7. Do you see expressions in their music preferences, movies, anime, hobbies, that are stereotypical for the opposite sex?
   0 Yes 0 No 0 Unclear

8. Do you observe whether the person prefers socializing with same-sex or opposite-sex groups?
   0 Yes 0 No 0 Both

Past

9. Did the person show a strong desire to be of the opposite sex as a child?
   0 Yes 0 No 0 Unclear

10. Did the person wear clothing typical for the opposite sex as a child?
    0 Yes 0 No 0 Unclear

11. Did the person show a strong preference for roles of the opposite sex in fantasy or imaginative play as a child?
    0 Yes 0 No 0 Unclear

12. Did the person show a strong preference for toys, games, or activities stereotypically associated with the opposite sex as a child? 0 Yes 0 No 0 Both

13. As a child, did the person have a strong preference for playmates of the opposite sex?
    0 Yes 0 No 0 No preference

14. As a child, did the person have a strong aversion to toys, games, and activities typical for their sex?
    0 Yes 0 No 0 Unclear

15. As a child, did the person have a strong aversion to their own sexual anatomy?
    0 Yes 0 No 0 Unclear

16. As a child, did the person have a strong desire for physical sex characteristics that match their experienced gender?
    0 Yes 0 No 0 Unclear

Family and Friends Survey - 2

Hand Over to Clinic

Questions about the Person's Background and Social Influence

1. Did the trans identity emerge abruptly during or after puberty without prior signs in childhood?
   0 Yes 0 No 0 Don't know

2. Do you think the person could be influenced by friends?
   0 Yes 0 No 0 Don't know

3. Are their transgender/non-binaries/'queer' people in their class or friend group?
   0 Yes 0 No 0 Don't know

4. Do you think online information plays a role in the person's self-diagnosis?
   0 Yes 0 No 0 Don't know

5. Do you think this person could be having other mental health conditions such as anxiety, depression, or autism spectrum disorder?
   0 Yes 0 No 0 Don't know
   If yes, what notable behavior does the individual exhibit?

6. Did the person behave differently as a child or before the expression of their self-diagnosis compared to now?
   0 Yes 0 No
   If yes, can you describe how that change appears?

7. Did the person distance from the family and/or former friends shortly prior or after his/her 'coming out as trans/non-binary'?
   0 Yes 0 No

8. Are most of their friendships and activities now related to their trans identity?
   0 Yes 0 No 0 Don't know

9. Do you have the impression that the person is confused about their identity and is making an incorrect self-diagnosis?
   0 Yes 0 No

10. Do you think for the person, a trans identity could just be a temporary interesting thing?
    0 Yes 0 No 0 Don't know

Family and Friends Survey - 3

Hand Over to Clinic

Additional Questions

1. Should the family's impression be strongly considered in the diagnosis?
   0 Yes 0 No
   Why do you think that?

2. Should the opinions of the primary care doctor and other healthcare providers also be sought and considered?
   0 Yes 0 No

3. Do you think the person might be homosexual or bisexual or asexual?
   0 Yes 0 No

4. Could there be inner shame about potential homosexuality in the person?
   0 Yes 0 No 0 Don't know

5. Could the family have problems with homosexual people?
   0 Yes 0 No 0 Don't know
   If yes, can you provide an explanation?

6.Could their religious group/workspace/sports club have problems with homosexual people?
   0 Yes 0 No 0 Don't know

7. Do you have insight into what makes the person unhappy with their body?
   0 Yes 0 No
   If yes, please clarify.

8. Have you yourself ever experienced serious gender related distress when you were younger, or now?
   0 Yes 0 No
   If yes, please clarify.

9. Is there anything else you would like to add with regards to the person's diagnosis or to this questionnaire?

10a. Informed Consent Question (Related to Males)

Medical literature documents the following major potential health complications*:

Puberty Blockers:

- Permanent impairment of sexual function, including fertility and no development of orgasm [32,33]
- Long-term effects on bone density (osteoporosis) and development [10]
- Negative impact on neuropsychological functioning [10]
- Underdeveloped genital tissue, potentially compromising future surgical options [11]

Estrogen Treatment (in combination with (off-label use of) anti-androgens):

- Increased mortality risk [12]
- Insulin resistance (33% of patients) with elevated diabetes risk [13]
- Increased cancer risk, particularly breast and liver, meningioma (brain membrane tumor), and liver damage
- 26x more chance to get testicular cancer (1 in 100 patients) [14]
- Significant weight gain and body fat redistribution
- Thrombosis (5% of transwomen, 22x higher than cis men) [15]
- Cardiovascular complications, death rate 2.6x higher [12]
- Severe muscle mass reduction
- Permanent infertility (very common) [16]
- Sexual function changes, impotence [17]
- Progressive bone density loss

Post-Surgical Complications (Following Vaginoplasty):

- Organ prolapses (up to 7.5%) [18]
- Urinary incontinence (up to 15%) [18]
- Chronic urinary tract symptoms (up to 20%) [18]
- Death caused by infections, death rate 9x higher [12]
- Sexual dysfunction (up to 75%) [18]
- No orgasm (studies are incredible flawed and present distorted numbers due to bad methodology)

Universal Considerations:

- **11% of the males (trans women) mean age 23, died after average 11 years** [12]
- Permanent dependence on hormone therapy and medical supervision [19,20]
- Substantial risk of severe medical complications [11,12,13,14,15,16,18, 21,22,23,24,25,26,27,32,33]
- No demonstrated mental health benefits (PB and CSH, surgery) [7]
- High probability of permanent reproductive and sexual loss [16]
- Persistent elevated suicide risk post-transition, death rate 7x higher among men [12]
- Irreversible changes with limited long-term research, effects not understood [28]
- Extreme limited dating pool causing loneliness, lack of intimacy, relational stress, depression...

Question to family member: Have you thoroughly reviewed these medical implications and determined this is the optimal treatment path, understanding the potential lifetime impacts? 0 Yes 0 No

Question to clinic: Have you thoroughly reviewed these medical implications, advised the patient of them, and determined that this is the optimal treatment? 0 Yes 0 No

***Dr. Stephen Levine** - The Reality Behind 'Trans' Youth Evaluations (Denver, USA, 2023)*

"I ask them before they start the hormones that if you get depressed, I want you to consider the possibility that it's because of your transition and not something else. And I want you to have the strength and courage to recognize that. Like many of us in life, you might have made a mistake.

As far as I can see endocrinologists almost never stop the application of hormones to the people they've started with. All the detransitioners, if you talk to them, stopped their hormones, not the doctor. ***Even when they're depressed, even when they've made a suicide attempt, the doctor continues the treatment.****"*

* Sources on page 17

10b. Informed Consent Question (Related to Females)

Medical literature documents the following major potential health complications*:

Puberty Blockers:

- Permanent impairment of sexual function, including fertility and no development of orgasm [34,35,36]
- Long-term effects on bone density (osteoporosis) and development [10]
- Negative impact on neuropsychological functioning [10]

Testosterone Treatment:

- Increased mortality risk [12]
- Progressive bone density loss (14% develops osteoporosis, 22% develops osteopenia) [29]
- Vaginal tissue atrophy [21] and urinary complications (87%) [22 30]
- Hysterectomy/oophorectomy (removal or the womb and ovaries) typically required after 3-5 years of treatment due to chronical problems [22]
- Chronic pelvic and genital pain [23]
- Permanent infertility [22]
- Ovarian cysts and endometrial complications [23]
- Metabolic disruption [24] and weight gain and appetite changes [26]
- Significant mood and emotional changes [10]
- Severe liver complications [25]
- Pelvic floor dysfunction (PFD) (94%) [30]
- Seksual dysfunction (53%) [30]
- Anorectal symptoms (45%) [30]

Post-Surgical Complications (Following Hysterectomy and Phalloplasty):

- Organ prolapse (up to 4%) [18]
- Urinary incontinence (up to 50%) [18]
- Chronic urinary tract symptoms (up to 37%) [18]
- Sexual dysfunction (up to 54%) [18]
- No orgasm (studies are incredible flawed and present distorted numbers due to bad methodology)

Universal Considerations:

- **3% of the females (trans men) mean age 30, died after average 5 years, a factor 3x than normal** [12]
- Permanent dependence on hormone therapy and medical supervision [19,20]
- Substantial risk of severe medical complications [11,12,13,14,15,16,18, 21,22,23,24,25,26,27]
- No demonstrated mental health benefits (PB and CSH, surgery) [7]
- High probability of permanent reproductive and sexual loss [16]
- Persistent elevated suicide risk post-transition, death rate 3.3x for women [12]
- Irreversible changes with limited long-term research, effects not understood [28]
- Extreme limited dating pool, causing lack of intimacy, relational stress, depression...

Testosterone is a Schedule III Drugs

A simplified overview; for a more detailed explanation, refer to the DEA drug scheduling.[31]

Schedule I:	Heroin, LSD, marijuana, MDMA (ecstasy), peyote
Schedule II:	Cocaine, methamphetamine, methadone, fentanyl, Dexedrine, Ritalin
Schedule III:	Ketamine, codeine (in certain formulations), anabolic steroids, **testosterone**
Schedule IV:	Valium, Xanax, tramadol
Schedule V:	Cough syrups containing low levels of codeine

It is often noted that girls who take testosterone initially view it as a positive experience. This isn't surprising, as testosterone can have stimulating effects similar to other drugs. While the first few years may feel like a 'honeymoon phase', over time, its mental and physical side effects often emerge, leading to what could be described as the 'hangover years'.

Question to family member: Have you thoroughly reviewed these medical implications and determined this is the optimal treatment path, understanding the potential lifetime impacts? 0 Yes 0 No

Question to clinic: Have you thoroughly reviewed these medical implications, advised the patient of them, and determined that this is the optimal treatment? 0 Yes 0 No

***Dr. Stephen Levine** - The Reality Behind 'Trans' Youth Evaluations (Denver, USA, 2023)*

> *"I ask them before they start the hormones that if you get depressed, I want you to consider the possibility that it's because of your transition and not something else. And I want you to have the strength and courage to recognize that. Like many of us in life, you might have made a mistake.*
> *As far as I can see endocrinologists almost never stop the application of hormones to the people they've started with. All the detransitioners, if you talk to them, stopped their hormones, not the doctor.* ***Even when they're depressed, even when they've made a suicide attempt, the doctor continues the treatment.****"*

* Sources on page 17

Family and Friends Survey - 4

Hand Over to Clinic

A Few Personal Questions

1. What is your age?

2. What is your level of education?

3. What is your most recent job position?

4. Are you religious?

0 Strong 0 Serious 0 Medium 0 I believe in something 0 Not at all

5. How would you describe your political orientation?

0 Left 0 Right 0 Center 0 Don't want to say

6. What is your stance on freedoms such as same-sex marriage, euthanasia, abortion, and gender transition (if well-researched)?

	same-sex marriage	euthanasia	abortion	gender transition
Fantastic that this is possible in our country	0	0	0	0
No problem with it	0	0	0	0
I don't care what others do	0	0	0	0
Concerning	0	0	0	0
Strongly against	0	0	0	0

Sources for informed consent questions on page 15 and 16:

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11 Zinnia Jones (December 2018) **Use of puberty blockers in transgender girls, effects on genital tissue development, and vaginoplasty options** https://genderanalysis.net/2018/12/use-of-puberty-blockers-in-transgender-girls-effects-on-genital-tissue-development-and-vaginoplasty-options/

12 C.J.M. de Blok et al. (Sep 2021) **Mortality trends over five decades in adult transgender people receiving hormone treatment: a report from the Amsterdam cohort of gender dysphoria** https://www.transvisie.nl/wp-content/uploads/2021/09/lancet-mortality-transgender.pdf

13 A. Maassen van den Brink & A.J. van Zonneveld (16 sep 2019) **De rol van hormonen bij migraine en diabetes** https://www.zonmw.nl/nl/artikel/de-rol-van-hormonen-bij-migraine-en-diabetes#:~:text='Als%20je%20wilt%20onderzoeken%20wat,ontwikkelt%2C%20een%20voorstadium%20van%20diabetes

14 E. M. Shanker et al. (2024) **Exploring the Incidence of Testicular Neoplasms in the Transgender Population: A Case Series** https://meridian.allenpress.com/aplm/article/doi/10.5858/arpa.2024-0218-OA/503894

15 M. Kerrebrouck et al. (20 Jan 2022) **Thrombophilia and hormonal therapy in transgender persons: A literature review and case series** https://pmc.ncbi.nlm.nih.gov/articles/PMC9621226/

16 Paula Amatoet al. **Fertility Details for Trans Women** https://www.fertilityiq.com/fertilityiq/trans-feminine-fertility/fertility-details-for-trans-women#transition-and-fertility

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19 M. Fradd **How the Medical World Is Creating Lifelong Patients** https://pintswithaquinas.com/how-the-medical-world-is-creating-lifelong-patients

20 M. den Heijer **Long term hormonal treatment for transgender people** https://www.bmj.com/content/bmj/359/bmj.j5027.full.pdf

21 P. J. Cheng et al. (June 2019) **Fertility concerns of the transgender patient** https://pmc.ncbi.nlm.nih.gov/articles/PMC6626312/

22 **Information on Cleveland Clinic website** https://my.clevelandclinic.org/health/diseases/15500-vaginal-atrophy

23 Juno Obedin-Maliver (June 2016) **Pelvic pain and persistent menses in transgender men** https://transcare.ucsf.edu/guidelines/pain-transmen

24 Leila Hashemiet al. (June 2024) **Gender-Affirming Hormone Treatment and Metabolic Syndrome Among Transgender Veterans** https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2820670

25 **Liver Care for Transgender and Gender-Diverse Individuals** https://www.uchicagomedicine.org/conditions-services/transgender-care-services/liver-disease-care

26 J. Mitchell (19 Aug 2021) **Testosterone linked to weight gain and higher rates of obesity among transmasculine people; physicians should monitor long term weight changes in transgender patients** https://www.bidmc.org/about-bidmc/news/2021/08/study-reveals-gender-affirming-hormone-therapies-impact-obesity-transgender-individuals

27 E. Abbruzzeseet al. (2 Jan 2023) **The Myth of "Reliable Research" in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies—and research that has followed** https://www.tandfonline.com/doi/full/10.1080/0092623X.2022.2150346

28 Helene Frances Hedian **Gender-Affirming Hormone Therapy (GAHT)** https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/gender-affirming-hormone-therapy-gaht

29 G. Giacomelli et al. (27 May 2022) **Bone health in transgender people: a narrative** review https://journals.sagepub.com/doi/full/10.1177/20420188221099346

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31 DEA United States Drug Enforcement Administration **Drug Scheduling** https://www.dea.gov/drug-information/drug-scheduling

32 Melissa Rudy (April 2024) **Puberty blockers could cause long-term fertility and health issues for boys, study finds: 'May be permanent'** https://www.foxnews.com/health/puberty-blockers-could-cause-long-term-fertility-health-boys-study-may-be-permanent

33 Murugesh et al.. 2024 **Puberty Blocker and Aging Impact on Testicular Cell States and Function** https://www.biorxiv.org/content/10.1101/2024.03.23.586441v1

34 D. Ehrensaft (2017) **Gender nonconforming youth: current perspectives** https://pmc.ncbi.nlm.nih.gov/articles/PMC5448699/

35 Bangalore Krsihna K. et al. (July 2019) **Use of Gonadotropin-Releasing Hormone Analogs in Children: Update by an International Consortium** https://www.karger.com/Article/FullText/501336

36 **Marci Bowers, President of WPATH, talking about Puberty Blockers**, YT, 29.06.2023 https://www.youtube.com/watch?v=kuwOx9YdHXY

Result Family and Friends Survey

Hand Over to Clinic

	Name of family member or friend	Relation to the person:
A :	.....	.....
B :	.....	.....
C :	.....	.....
D :	.....	.....
E :	.....	.....
F :	.....	.....
G :	.....	.....
H :	.....	.....
I :	.....	.....
J :	.....	.....
K :	.....	.....
L :	.....	.....

Use the following color codes to indicate responses: **Yes:** Green **No:** Red **Both/Unclear:** Orange

Part 1 - Based on the DSM-V-TR

Present	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**
Question 1	0	0	0	0	0	0	0	0	0	0	0	0
Question 2	0	0	0	0	0	0	0	0	0	0	0	0
Question 3	0	0	0	0	0	0	0	0	0	0	0	0
Question 4	0	0	0	0	0	0	0	0	0	0	0	0
Question 5	0	0	0	0	0	0	0	0	0	0	0	0
Question 6	0	0	0	0	0	0	0	0	0	0	0	0
Question 7	0	0	0	0	0	0	0	0	0	0	0	0
Question 8	0	0	0	0	0	0	0	0	0	0	0	0
Past												
Question 9	0	0	0	0	0	0	0	0	0	0	0	0
Question 10	0	0	0	0	0	0	0	0	0	0	0	0
Question 11	0	0	0	0	0	0	0	0	0	0	0	0
Question 12	0	0	0	0	0	0	0	0	0	0	0	0
Question 13	0	0	0	0	0	0	0	0	0	0	0	0
Question 14	0	0	0	0	0	0	0	0	0	0	0	0
Question 15	0	0	0	0	0	0	0	0	0	0	0	0
Question 16	0	0	0	0	0	0	0	0	0	0	0	0

Part 2 - ROGD Indicator

Question 1	0	0	0	0	0	0	0	0	0	0	0	0
Question 2	0	0	0	0	0	0	0	0	0	0	0	0
Question 3	0	0	0	0	0	0	0	0	0	0	0	0
Question 4	0	0	0	0	0	0	0	0	0	0	0	0
Question 5	0	0	0	0	0	0	0	0	0	0	0	0
Question 6	0	0	0	0	0	0	0	0	0	0	0	0
Question 7	0	0	0	0	0	0	0	0	0	0	0	0
Question 8	0	0	0	0	0	0	0	0	0	0	0	0
Question 9	0	0	0	0	0	0	0	0	0	0	0	0
Question 10	0	0	0	0	0	0	0	0	0	0	0	0

Part 3 - Additional Questions

Question 1	0	0	0	0	0	0	0	0	0	0	0	0
Question 2	0	0	0	0	0	0	0	0	0	0	0	0
Question 3	0	0	0	0	0	0	0	0	0	0	0	0
Question 4	0	0	0	0	0	0	0	0	0	0	0	0
Question 5	0	0	0	0	0	0	0	0	0	0	0	0
Question 6	0	0	0	0	0	0	0	0	0	0	0	0
Question 7	0	0	0	0	0	0	0	0	0	0	0	0
Question 8	0	0	0	0	0	0	0	0	0	0	0	0
Question 9	0	0	0	0	0	0	0	0	0	0	0	0
Informed Consent Question												
Question 10 **Transition?**	0	0	0	0	0	0	0	0	0	0	0	0

Signature of Parents: Date:

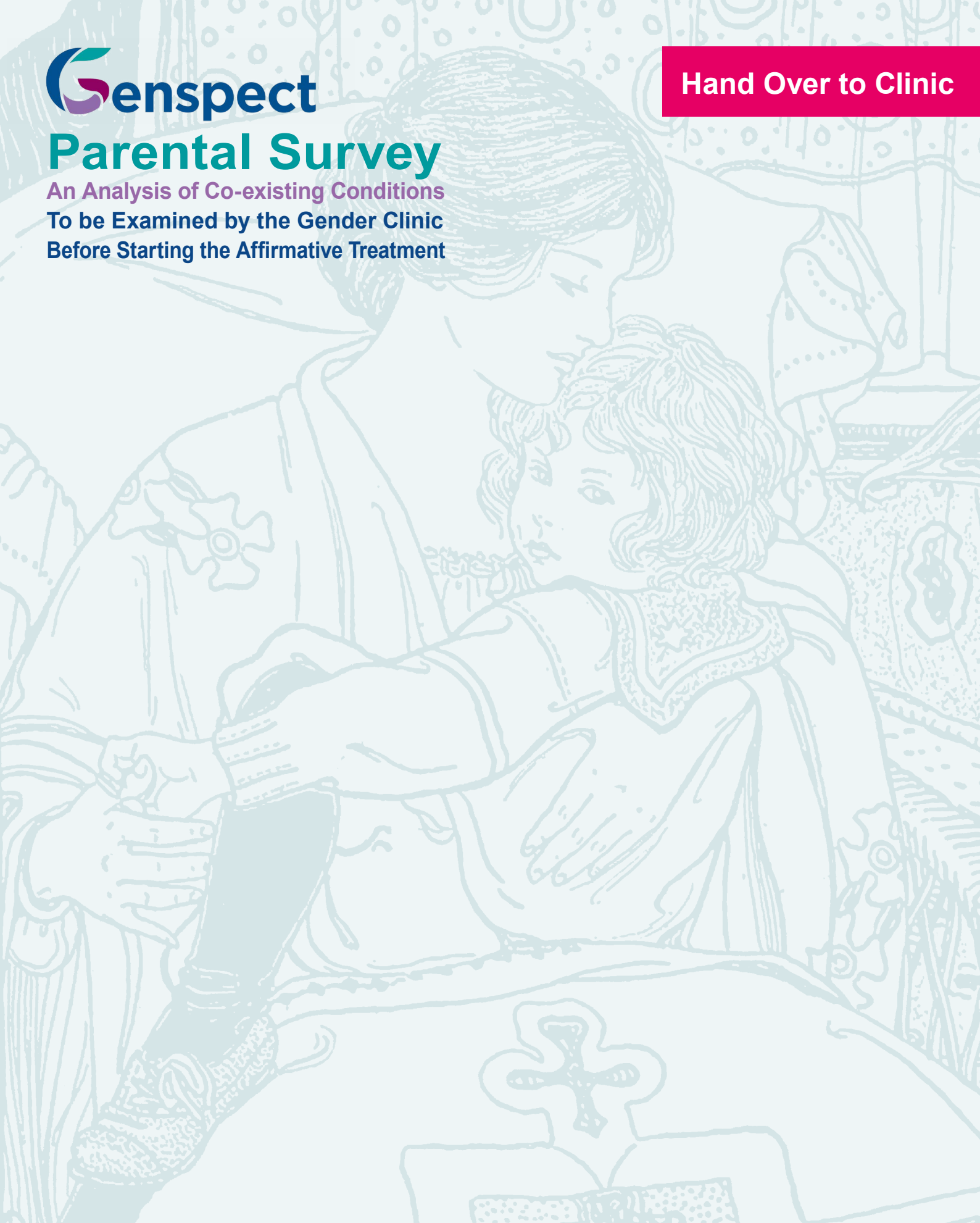
Genspect

Parental Survey

An Analysis of Co-existing Conditions

To be Examined by the Gender Clinic
Before Starting the Affirmative Treatment

Hand Over to Clinic



Gender-related issues are complex.
You or those around you may not understand every aspect. Don't hesitate to ask for help. Reach out to other parents. Ask questions in relevant online groups. Reach out to organizations specialized in gender-critical topics.

Possible Co-existing Conditions

As a parent, please indicate (in the green 'yes / no row') whether you observe any of the following characteristics that may be relevant to your child's self-reported gender incongruence. Cross out the answer (Yes or No) that does not apply.

For each characteristic you observe, ask the clinic if they acknowledge this in their assessment as well.

Most Important and Most Frequent Occuring Co-Existing Conditions	**Family:**	**Clinic:**
Internalized homophobia	yes / no	yes / no
Self-hatred	yes / no	yes / no
Autism	yes / no	yes / no
Loneliness	yes / no	yes / no
Symptoms of ROGD		
The coming out as trans was completely unexpected	yes / no	yes / no
The coming out does not match the expected image of a 'trans person'	yes / no	yes / no
Social contagion through friends	yes / no	yes / no
Social contagion through the internet	yes / no	yes / no
Mental deterioration after coming out	yes / no	yes / no
A sudden increase in lying	yes / no	yes / no
Sudden changes in behavior after coming out	yes / no	yes / no
Shame or reluctance to express oneself as the opposite sex (e.g., toward family)	yes / no	yes / no
Creation of two separate worlds (home/family vs. friends or school, triangulation)	yes / no	yes / no
Seeking (negative) attention (therefore claiming to be 'trans' or 'non-binary')	yes / no	yes / no
Trauma		
Experienced bullying now or in the past	yes / no	yes / no
Issues because of divorced parents	yes / no	yes / no
Teenage anxieties	yes / no	yes / no
History of sexual abuse	yes / no	yes / no
Experience of physical violence	yes / no	yes / no
Immaturity, Social and Relational Issues		
Immature or childish behavior	yes / no	yes / no
Little or no experience with boy- or girlfriends	yes / no	yes / no
Reluctance to touch people (and potential partners)	yes / no	yes / no
Hatred of heteronormativity (or, for example, 'the patriarchy' if male)	yes / no	yes / no
Extreme political beliefs	yes / no	yes / no
Psychological Issues		
Any former diagnosis of a disorder (Based on the DSM)	yes / no	yes / no
ADHD or ADD	yes / no	yes / no
Body Dysmorphic Disorder (BDD) (dissatisfaction with body parts)	yes / no	yes / no
Self-harm (like cutting, scratching, anorexia, bulimia...)	yes / no	yes / no
Fear of attachment	yes / no	yes / no
Sexual anxieties	yes / no	yes / no
Signs of narcissistic traits (inflated self-image or Peter Pan syndrome)	yes / no	yes / no
Signs of borderline traits (triangulation, conflictual, self-harm, threatening with leaving)	yes / no	yes / no
Factitious disorder (ICD 6D50, DSM-5-TR 300.19) (possible other issue instead of trans)	yes / no	yes / no
If female: Expressed hostility toward conventionally masculine men	yes / no	yes / no
If male: Expressed hostility toward conventionally feminine women	yes / no	yes / no
Transmaxxing [37]	yes / no	yes / no
Autogynephilia [38], Transvestic Fetishism (a paraphilia, in the DSM-5-TR 302.3 (F65.1))	yes / no	yes / no
Other unspecified characteristics 1:	yes / no	yes / no
Other unspecified characteristics 2:	yes / no	yes / no
Other unspecified characteristics 3:	yes / no	yes / no

Question to clinician:

For each item marked different from the parental view above, please provide your clinical rationale for why your assessment differs from the family's observations.

37 **Transmaxxing** is a controversial phenomenon where males, primarily from "incel" (involuntarily celibate) online communities, pursue gender transition for perceived social advantages rather than due to gender-related distress, such as better social treatment or escape from masculine social pressures.

38 **Autogynephilia (AGP)** is a **paraphilia** characterized by sexual arousal at the thought of being a woman. This condition can lead to problematic outcomes if surgical interventions are pursued, as procedures like castration result in diminished libido, leading to significant regret. AGP represents a paraphilic condition rather than a gender identity, and gender-affirmative treatment is not recommended (**Dr. Az Hakeem - *DETRANS: When Transition Is Not the Solution***, ISBN 979-8862184549).

Questions for the Specialist Related to Ethical Issues and Responsibility

The current gender-affirmative care protocols demonstrate a notable absence of clinical guidance regarding long-term implications for **intimate relationships** and **sexual function**. This critical omission requires urgent attention, particularly given that procedures involve permanent physiological modifications.

1. What documented protocol does the clinic use to differentiate gender-related distress from other conditions based on objective clinical criteria?

2. How does the clinic ensure that body modification interventions do not harm long-term intimate functioning or other crucial aspects of life?

3. What clinical criteria validate a person's self-reported gender-related distress, and what evidence-based support justifies these interventions, given that self-reported distress is subjective and unmeasurable?

4. Please provide your protocol for authorizing permanent interventions for gender-related distress, particularly when similar interventions (e.g., FGM or voluntary amputation) are prohibited for other body-related conditions. What is the evidence-based rationale for this distinction?

5. What protocols establish medical necessity and informed consent, especially in the absence of long-term outcome data?

6. 'In dubio abstine' (When in doubt, refrain) is a foundational principle in medical ethics. Does gender-affirming care align with this principle?

7. Please read the anecdote of the father below. Are we dealing with a variant of Hannah Arendt's 'Banality of Evil'?

8. Plastic surgery generally adheres to the principle of preserving natural form; for example, tails are not added, nor are eyes removed to create a cyclops. Does this ethical standard apply within your protocol? We ask this specifically regarding the gender identities non-binary, nullo*, and eunuch*. Is it ethical and legal to address these identities surgically?

9. Is it ethical to assist individuals in fulfilling their desires if doing so leads to societal disruption, such as family breakdown or the erosion of women's rights?

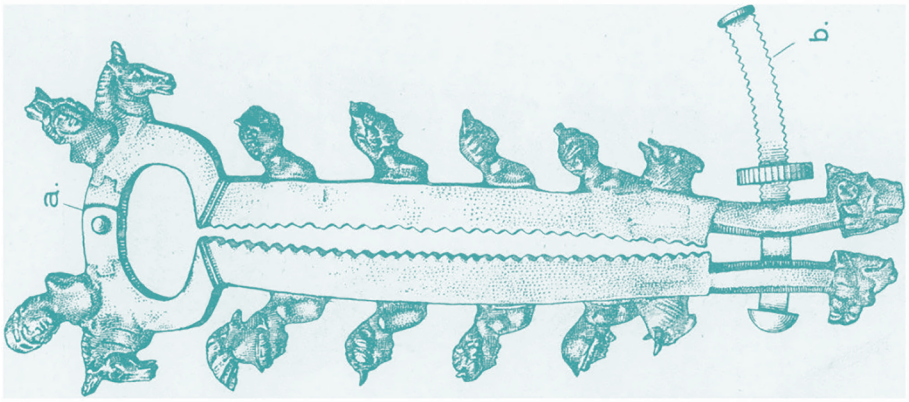
10. Given the substantial limitations in evidence-based validation for the gender-affirmative model, is it ethical to ask family members to place trust in this process?

Logical thinking, please answer

11. If gender identity is both innate and unchangeable, as gender theory suggests, yet includes fluid identities, how can medical interventions be deemed necessary without violating 'do no harm' and 'in dubio abstine' given this inherent paradox?

12. Gender affirming care: if genitals don't define gender, how does removing them affirm it?

These questions aim to clarify the clinical reasoning process and documentation supporting current treatment protocols.



Father Asking Questions in the Dutch Clinic

> *"The conversation with the clinical psychologist went deeper than asking what percentage of people who transition experience trans regret. That question is incomplete. The real question should be whether people have an improved quality of life through sex reassignment procedures. And here comes the most remarkable statement from the clinical psychologist:* ***"Transitioning does not make you happy."*** *We responded,* ***"Huh? Then why do we do it?!"*** *The clinical psychologist repeated this statement several times during our conversation. We were shocked to hear this admitted so openly.* ***We still do not understand it.****"*

*A nullo is someone who has all sexual characteristics removed: breasts, internal and external genitalia, but also, for example, nipples and the navel. In the most extreme case, only the urinary opening remains. The eunuch identity is mentioned in the infamous chapter 9 of WPATH's SoC8 and the Dutch Somatic Transgender Care Model 2024, pages 23-29. This is a sadomasochistic fetish of 'cutters' and 'wannabees'.

15 Scientific Questions for the Specialist

The remarkable list from Levine, cited on page 10, raises **14 crucial scientific questions**. These questions can help parents engage in a critical and constructive conversation with specialists about the assumptions underlying the gender-affirmative care model.

1. Is it scientifically proven that a trans identity, once established, is truly immutable and unchangeable for life?

2. What evidence supports the idea that trans identities are primarily caused by prenatal biological factors? Could this theory be oversimplifying a complex issue?

3. How can it be claimed that sexual orientation and gender identity are entirely independent, when developmental patterns often suggest they are interconnected? Doesn't early medicalization limit the discovery of homosexuality?

4. Is it reasonable to assume that no form of gender identity could ever reflect an underlying psychological issue?

5. How can it be stated that gender dysphoria is a serious medical condition, yet treatment is only necessary if the patient desires it?

6. Are the emotional challenges faced by children with gender dysphoria entirely caused by discrimination, or could other pre-existing psychological factors be contributing?

7. Why is it often claimed that there are no effective alternatives to affirmative care when other approaches exist?

8. Is it ethical to equate all forms of psychotherapy for gender dysphoria with conversion therapy, and should such therapy be universally outlawed? Isn't medical transition a conversion of the sexual body?

9. On what scientific grounds is it asserted that affirmative care leads to lasting improvements in mental health and social functioning?

10. Is there credible evidence that affirmative care reduces suicidal ideation and prevents suicide in the long term, especially in light of studies showing elevated suicide rates among post-surgery adults?

11. How can we be confident that young teens know what will bring them long-term happiness, given the developmental and cognitive changes they are still undergoing?

12. Does meeting the diagnostic criteria for gender dysphoria guarantee a good outcome with affirmative care, or are there cases where it does not?

13. If regret and detransition are rare, why are reports of detransition becoming more frequent, and could the current definitions of "regret" be too narrow to capture the full picture?

14. How can the clinic justify using a DSM diagnosis, which by definition is a snapshot, as a basis for permanent, irreversible bodily modifications?

15. The 14 questions above encapsulate the foundational claims surrounding affirmative care. If the ideas themselves are untrue or scientifically unsupported, how can we trust the interventions based on them?

Some Important Steps

Write out the History and Your Views on the Issue

We recommend organizing your thoughts by writing a detailed letter. Describe how the situation began, outline your child's behavioral characteristics, and share your perspective on what you believe is happening. Provide this letter to both the gender clinic and your primary care doctor. **Send a printed version via Registered Mail with Return Receipt for official documentation and send also a copy via email for quicker communication.**

Report Signs of Shame, Problematic Behavior and Unrealistic Expectations

If the survey results suggest shame related to gender expression (or other behavioral problematic indicators), the gender clinic must address this issue. Any concerns raised by you or other relatives should prompt a clear and logical follow-up, with an explanation of the clinic's approach. **Shame is fundamentally incompatible with medicalization**, as it can exacerbate iatrogenic harm when physical changes from medical interventions become noticeable. It is crucial that the person overcomes feelings of shame before proceeding with any further steps.

Your Primary Care Doctor is Your Ally

Share your concerns with your primary care doctor in a written document, supported by credible sources that validate your concerns. The ongoing medical controversy surrounding gender-affirming care is still unfolding, and many primary care doctors may not yet be fully informed, often relying on trust in the clinics—a phenomenon known as the "chain of trust." It is your responsibility to present the shortcomings of gender-affirmative care that you have identified in the literature. Additionally, communicate with your primary care doctor how you feel about your treatment as a parent within the clinic, particularly if your views are dismissed, not taken seriously, or if you are excluded from discussions about your child's care.

What is the Specialist's Level of Knowledge and Experience?

Make a list of questions and ask for written answers. Ask the specialist about the sources you have read. Has the specialist reviewed this literature as well? If not, what qualifies them as an expert? What is the specialist's level of knowledge and experience?

Request to the Gender Clinic to Consult the Primary Care Doctor

It is advisable to request that the clinic consults with the primary care doctor to include their perspective. **If the primary care doctor's opinion differs from that of the gender clinic, it should not be dismissed without a clear and logical explanation.** Making this request encourages the clinic to act transparently and responsibly, helping to mitigate potential legal issues in the future.

Send Copies of the Survey to Your Primary Care Doctor and the Insurance Company

We recommend sharing the completed survey with your **primary care doctor** and **insurance company** to ensure all parties involved are well-informed about the complex issues surrounding medical transition. Since a diagnosis of Gender Dysphoria cannot be objectively measured, it is crucial to communicate the survey results to the insurance company, especially if they differ from your child's self-diagnosis. This ensures the clinic is held accountable for explaining why self-diagnosis takes precedence over the family's perspective and justifying why medical interventions, which carry significant health risks, are deemed the only viable solution. **Send the letter in a printed version via Registered Mail with Return Receipt, and also forward it by email for quicker delivery.**

Parental Statement

Hand Over to Clinic

Entering a Legal Minefield

Once a diagnosis has been made, the clinical statement must clearly refute the afore-mentioned concerns. It is essential that all potential contributing factors to the person's self-reported gender incongruence receive thorough investigation. Addressing these factors might lead to resolution of the presenting concerns and potentially eliminate the need for irreversible medical interventions.

Additionally, it must be demonstrated to what extent co-existing conditions are present and why they do not constitute diagnostic overshadowing.

A carefully documented investigation that addresses co-existing conditions is crucial, especially given the drastic and irreversible procedures performed by clinics. **We have clear indications that such reporting is currently lacking, which could lead to significant legal problems.** Insurance companies appear unaware of these issues. Once they become aware, fundamental questions are likely to be raised to avoid legal and financial risks. Sending the outcomes of our survey to the insurance companies helps raise awareness.

Moreover, we must not forget that parents' long-term knowledge of and proximity to their child are not recognized in the decision-making process. This systematic dismissal of parental input creates significant medico-legal concerns. **How is it possible that gender clinics systematically dismiss this crucial source of clinical information?**

Now that this survey is available, the question arises when parental impressions have been considered. Can clinics demonstrate this was done adequately in past cases? And how do historical clinical decisions align with the results from families who have completed our systematic assessment?

It is expected that this survey will create significant challenges for gender clinics, especially as it becomes apparent that parental impressions have been systematically ignored. It can no longer be maintained that parental input is irrelevant, particularly now that there is concrete evidence of the value and impact of our information through this survey and your collective responses to these questions.

If the clinic wishes to proceed with further treatment involving medication and surgery, we as parents request that you address each of our questions point by point and send your responses to the address mentioned below.

Parental Statement

With this statement, we as parents are issuing a clear warning that we believe 'gender-affirmative treatment' should not proceed.

Should the clinic invoke patient privacy, we will forward this document to our family doctor and the insurance company. This way, these parties can collaborate with the clinic to make a well-considered decision. This means that all parties will share responsibility should complications arise post-treatment, unless they also advise against treating the patient. It is fair, in case of harm, compensation and/or reconstructive medical care is provided at the will of the patient.

Date:
[Insert Date Here]

Name of Parent/Family Member:
[Insert Name Here]

Signature of Parent/Family Member:
[Insert Name Here]

Address:
[Your Address Here]

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VOORZIJ voor vrouwen

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STATS FOR GENDER.ORG

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LGB ALLIANCE

Stephanie Davies-Arai - Director of Transgender Trend

"I spend those first few years talking to ***parents who were in this terrible position of not only having a real problem with their teenager, but having the whole world against them and the whole world thinking they were bigots.***

And so normally when you have teenage problems, your child gets involved with the wrong crowd, into drugs, into drinks, into sex ... You know all these teenage problems... at least you have the support of the society around you. You have people who have some sympathy, some people who blame you, but you get sympathy. You can talk to your friends. So I was talking to parents who couldn't even talk to their friends, because they were afraid of being told they were bigots or transphobic."

Dr. Stephen B. Levine

*"****Parents (of trans-identified children) just need to be given the opportunity to speak****, share their views. Mental health professionals have to help their minor patients to talk. Even very intelligent patients because* ***they lack the deep understanding of themselves.*** *And of course, they lack a deep understanding of others. They don't have sufficient vocabularies for psychological phenomenon, and they of course have limited life experiences with which to judge their own experiences.*

The vast majority of parents that I've worked with over 50 years profoundly love their child. They are not the child's enemy. ***That adolescents perceive parents as the enemy reflects their limited, immature understanding.****"*