Dear American Academy of Pediatrics (AAP):

We need you and our children need you. There is a great and growing disservice that needs your attention, scientific curiosity, critical thinking, clinical experience, and compassion.

We have serious concerns about the AAP’s Policy Statement “Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents” (Rafferty et al., 2018). While we believe that AAP’s intention behind this position statement is to protect the health of today’s gender-diverse youth (children through young adults), we are deeply concerned that the clinicians using affirmation therapy are inadvertently inflicting physical and psychological harm.

We are members of a rapidly growing online community of over 1,100 parents of transgender-identifying youth who need your help. We have no unifying political affiliation. We empathize with mature transgender-identifying people who deserve respect. We need to stop the harm to our children.

It is our concern that the AAP’s Policy Statement will continue, and possibly worsen, the harm brought to many children by the recent radical changes to treatment guidelines for transgender-identifying youth.  Over the past decade, there has been an exponential rise of predominantly adolescent girls who are suddenly declaring themselves trans after the onset of puberty and who have no previous history of gender dysphoria (GD).  Historically, GD showed at a much earlier age and has been exceedingly more common in boys. A recent groundbreaking study of an emergent late-onset, predominantly female trans-identifying patient population, finds significant parallels with the phenomenon of eating disorders, and includes social contagion as a key factor (Littman, 2018).  The drastic increase in trans-identification and the switch to the predominant adolescent girl patient has prompted the United Kingdom (UK) Government to launch an investigation over concern that the 4400% increase in the last decade could be due to a social phenomenon (Rayner, 2018).

There is great harm being done to girls and some boys by medicalizing their gender non-conforming (GNC) behavior based on gender stereotypes, homosexuality, and/or underlying mental health issues that have led to trans-identification. The medicalization with gonadotropin releasing hormone (GnRH) agonists is highly experimental and comes with serious long-term consequences for bone health, potentially for neurological health, and as sterilizes the child when followed by cross-sex hormones. The harms of sex-aligned hormones (e.g., testosterone given to natal males) are well-known, include significant cardiovascular disease, and are increasingly exposed in lawsuits for non-transgender adults. Astonishingly, cross-sex hormones are given to the opposite sex in trans-identifying adolescents who are expected to be treated for their full lives and have permanent effects. The harms of surgeries are self-evident and irreversible, which is problematic for youth who change their minds.

The justification for non-FDA–approved medicines and surgeries is that the youth will commit suicide if these drastic measures aren’t taken (although this is not acknowledged in the AAP’s statement). There is no clinical data that supports that medical transition prevents suicide. Contrarily, long-term studies (>10 years) demonstrate increases in suicide rate, psychiatric hospitalization, and lower quality of life after sex reassignment surgery in adults (Dhejne et al., 2011; Simonsen et al., 2016; Kuhn et al., 2009).

Most transgender youth in the US who were reported in the news as having completed suicide were affirmed by social transition; thus, disproving that affirmation prevents suicide completion. The Williams Institute California GNC study reported that the percentage of teens identifying as either highly GNC or as androgynous has increased to nearly 30% and that neither group statistically differ from non-GNC teens in rates of lifetime suicide thoughts and attempts (Wilson, 2017). Furthermore, the risk of suicide in transgender-identifying youth is comparable or even less than that of youth who are non-heterosexual but who are not trans (CDC 2018, page 24, col 2, para 5), who have eating disorders (Smith, 2018), or who are referred to youth mental health services in the UK (GIDS, 2018) and yet, the “transition or die” mantra pervades as if transition is the only option.

We ask that you (1) consider our knowledge-based concerns presented as a scientific rebuttal to five main points made in the AAP position statement, (2) query AAP and other pediatricians anonymously to understand broader views, (3) conduct a more inclusive scientific debate with GD experts critical of affirmation therapy (e.g., gdworkinggroup.org) and (4) retract the AAP statement pending your inquiry. Please consider this letter a call to lead the way in exploring alternative non-invasive, non-harmful treatments. Your AAP oversight over the smaller subcommittee of “trans experts” is urgently needed.

1. **The problem of diagnosis**

*Rafferty et al. state “transgender identities and diverse gender expressions do not constitute a mental disorder.” (p 4) and “Some youth who identify as TGD also experience gender dysphoria, …” (p 3)*

If transgender-identification is not a mental disorder, what is it? Is it a medical condition? If so, how is it diagnosed? How can the TGD “condition” be both a mental health disorder for “some youth” and not for others but both are treated the same way?

These questions are never answered directly by Rafferty et al. or other “trans experts,” as well as the American Psychological Association (APA) and the World Professional Association for Transgender Health (WPATH) because the answer is simply that the youth just needs to proclaim that they are transgender – it is purely self-diagnosed.

If “being transgender or gender diverse” isn’t a mental disorder or a medical condition, why are youth treated with the life-altering, non-FDA-approved drugs (experimental GnRH agonists are used for years and hormone therapies are used for a lifetime) and irreversible, serial cosmetic surgeries in an attempt to achieve a scientifically impossible goal?

We have experienced doctors giving prescriptions without adequate mental health consideration and after only 1-2 visits.

***Summary****: Diagnosis is the youth’s self-diagnosis. The life-altering medical treatments offered do not match the diagnostic process or the clinical evaluation standards of medicinal or surgical safety and efficacy.*

1. **The problem of mental health and Trans-Identification ‘chicken and the egg’**

*Rafferty et al. acknowledge that trans-identifying youth have “high rates of depression, anxiety, eating disorders, self-harm, and suicide” (p 3) and that “If a mental health issue exists, it most often stems from stigma and negative experiences rather than being intrinsic to the child” (p 4)*

The view that trans-IDing youth have mental health problems *because* of their incongruity with their natal sex is a widespread assumption among “trans experts.” Another valid hypothesis is that mental health issues *cause* the person to trans-identify. Normal adolescent challenges coupled with the recent unfortunate declines in adolescent mental health (e.g., increases in anxiety, depression, self-harm, and suicide), the social media and iPhone explosion (Twenge et al., 2017), and the plethora of platforms targeting youth with transgender promotion are a recipe for adolescent trans-identification.

The role that mental health plays in a sudden proclamation of transgender status is discussed in a peer-reviewed scientific study that only begins to investigate the social influences on trans-identifying youth and reveals the emergence of rapid-onset gender dysphoria (ROGD; Littman, 2018).

Physicians, GD experts and clinicians have been critical of the rush to affirm an adolescent’s trans-identification, especially where no history of GD exists. Some of these professionals are part of the Pediatric and Adolescent Gender Dysphoria Working Group (gdworkinggroup.org), but many, including several AAP pediatricians are not voicing their concern in public for fear of career reprisal (Kearns, 2018).

Trans-identification offers a way out of the misery of poor mental health, misogyny, loneliness, and hatred of oneself. It offers a completely new identity (i.e., it’s identity suicide with the advantage of being reborn). Trans-identification provides body alteration, commands authority figures to alter their language and behavior, comes with a fight for social justice, and provides a sense of belonging. Can you see this ultimate recipe for disaster? We see it playing out in our homes every day and it is torture that this is therapist- and pediatrician-sanctioned and encouraged.

***Summary***: *We have experienced that providers (pediatricians, psychologists, etc.) do not explore, or only superficially inquire about, on-going or historical mental health, trauma experiences, or any potential causes of trans-identification before affirming the child’s self-diagnosis and proceeding with medical treatment, which is consistent with Dr. Littman’s study. We have also experienced that our children are using transgender-identification as a maladaptive coping mechanism as discussed in Dr. Littmans’s study. This idea is also supported in the context of anorexia nervosa and demonstrates similar adolescent clinical presentation profiles and social contagion aspects with the modern additional factor of pervasive social media exposure to transgender promotion.*

1. **The problem of ignoring desistance and detransition**

*Rafferty et al. state “…children who are prepubertal and assert an identity of TGD know their gender as clearly and as consistently as their developmentally equivalent peers who identify as cisgender…” (p 4)*

Eleven scientific studies indicate that transgender-identification is transient in most youth as demonstrated by desistance from transition and/or ceasing trans-identification after puberty (Cantor 2017). The dismissal of all 11 of these studies by Rafferty et al. is not scientifically validated by two citations consisting of opinion statements written by pro-affirmation extremists (Ehrensaft, 2018; Olson, 2016) who decide to throw out all the data that was astonishingly reproducible. All 11 studies demonstrate 60-90% of prepubertal children desist and further detailed scientific discussion has refuted criticisms of this unanimity of research findings (Zucker, 2018). In fact, two of the three references cited by Rafferty et al. that are used erroneously to cite support for affirmation therapy (see below under “the problem of not applying clinical science”), state that fewer than 20% of children persist in their transgender identity following puberty. In addition to the clinical data, desistance and detransition occur regularly as evidenced by verified published anecdotal accounts in several publications, all in 2018 alone (Anderson, 2018; Brunskell-Evans, 2018; Hope, 2018; Singal, 2018; Sullivan, 2018).

Several GC forum members are parents of desisters. Some of our children recognize that their trans-identification was part of a maladaptive coping mechanism. One girl desister says she was “ridiculously shy and incredibly awkward” and states that “I became depressed and I hated myself. I hated everything about me: my body, the way my voice sounded, my awkward personality, my face. Everything. I began questioning why I felt so awkward in my body and why I hated myself. I started questioning my gender. Not before long, I was 100% sure that I was actually a boy.” Many of our children have comorbid mental health issues and many watched some of the top 100 YouTube transgender celebrity vloggers in admiration just prior to their trans-identification.

Our families have experienced tremendous and unnecessary suffering brought on by irresponsible transgender promotion and iatrogenic therapy and there are thousands more who are trans-identifying for the same wrong reasons and yet they are 100% convinced of their self-diagnosis as well as their therapists, teachers, doctors, and some parents who accept their self-diagnosis as recommended by APA, WPATH, and now, AAP.

***Summary****: Desistance is the most common outcome among children. Persistence of the exponentially increased population of predominantly natal female, late-onset GD adolescents (including those newly identified as having ROGD) has not been studied. Today, youth are affirmed and either receive treatment or wait until they can get treatment, thus ensuring that they will be more likely to persist. Mistaken medical affirmation leading to detransition occurs regularly.*

1. **The problem of transgender-identification etiology**

*Rafferty et al. state “gender identity evolves as an interplay of biology, development, socialization, and culture…” (p 4)*

Three of these factors in determining if a youth will trans-identify can be summarized as the effect of the environment on the youth’s cognitive processes during development. This is exactly as we have experienced; these social factors are the dominant factors, and not biology. Evidence for social contagion is emerging in the literature (Littman, 2018) and is consistent with our experiences. By immersing themselves in trendy transgender-indoctrinating videos recommended when they open YouTube or when their friend groups decide they are transgender together in clusters, they become myopically fixated on transition.

When the natural developmental pubertal processes are artificially ceased by treatment with GnRH agonists, this negates the adolescent’s natural ability to desist from gender confusion. The majority of gender dysphoric youth desist after puberty, thus, stopping these profoundly important integrated developmental processes of neurochemistry and physiology can prolong persistence of GD. This is demonstrated by gender clinics admission that approximately 100% of children on GnRH agonists continue onto cross-sex hormones (Olson, 2018). It is also demonstrated in a study conducted at the Gender Identity Development Service (GIDS) where “persistence was strongly correlated with the commencement of physical interventions such as the hypothalamic blocker (t=.395, p=.007) and *no patient* within the sample desisted after having started on the hypothalamic blocker. [In contrast,] 90.3% of young people who did not commence the blocker desisted. For the children who commenced the blocker, feeling happier and more confident with their gender identity was a dominant theme that emerged during the semi-structured interviews at 6 months. However, the quantitative outcomes for these children at 1 years’ time suggest that they also continue to report an increase in internalising problems and body dissatisfaction, especially natal girls. [emphasis added]” as presented at a WPATH symposium (Carmichael, 2016).

As for the biological underpinnings of transgenderism, we know that it is not purely genetic as demonstrated by only 28% concordance in monozygotic twins and we know little else. Neuroimaging studies provide no unifying observations. The few MRI studies that show a minor difference in neuroanatomical substructures, gray matter volume, or cortical thickness are overtly flawed by the use of subjects who have been living daily life as a transgender individual (years of neuroplasticity at play), many have been using cross-sex hormones resulting in a myriad of neuroendocrine and potential neuroplastic changes, and most egregiously, cannot possibly rule out the probability that these small differences are due to personality differences such as the tendency to engage in behavior that is stereotypically associated with the opposite sex (gender non-conforming [GNC]) or such as homosexuality.

Most kids who desist grow up to be gay (Wallien et al., 2008). Are we converting “gays” to “straights”? Perhaps extremes on both sides of the political spectrum have motivations to accept or even encourage their child to trans-identify. Far-right parents may be embarrassed by GNC behavior and homosexuality and far-left parents may be eager to embrace the latest civil rights movement.

We are accepting of our kids’ GNC behavior and/or homosexuality. We don’t accept that their bodies are wrong and need to match gender stereotypes or become heterosexual.

***Summary:*** *There are several factors and individual trajectories leading a youth to trans-identify with the most dominant factors being environmental. The “trans experts” have ignored all environmental factors, attempted to over-emphasize any biological components, failed to tease-apart GNC behaviors or homosexuality from any minor biological basis of transgender identification, and focused solely on the false position that the youth is infallible in their self-diagnosis despite conclusive clinical evidence that children diagnose themselves incorrectly 60-90% of the time.*

1. **The problem of not applying clinical science**

*Rafferty et al. states “There is a limited but growing body of evidence that suggests that using an integrated affirmative model results in young people having fewer mental health concerns whether they ultimately identify as transgender.” (p 4)*

Two of the three references provided to support this statement contain no data and do not reference clinical data supporting this claim (Edwards-Leeper, 2012; Menvielle, 2012). One reference is a parent survey with inclusion criteria of parents who were seeking affirmation therapy and therefore biased in their ratings of affirmation therapy (Hill et al., 2010). Numerous other flaws include that some surveys were completed at baseline before affirmative care was administered and that the sample was unrepresentative of the study populations used for comparison in terms of social class and an unusually high adoption rate (52%). All these flaws and more have been eloquently discussed in Singh et al., 2011.

Rafferty et al.’s “growing body of evidence” turns out to be an erroneous, unsupported claim. The use of citations to support affirmation therapy were fact-checked by Clinical Psychologist James Cantor (Cantor, 2018). His critical commentary reveals how the citations actually demonstrate that the most common outcome of GD is desistance, the watchful waiting approach (not affirmation) is the approach recommended by most experts and institutions, and the citations used to claim that therapists opposed to affirmation therapy are engaged in conversion therapy have nothing to do with GD because they are studies on homosexuality (not GD). There are no comparative clinical studies between (1) affirmation therapy, which includes consideration or engagement in affirmative pharmaceutical therapies and serial cosmetic surgeries and (2) other non-affirmation therapies that exclude medicalization (but it can be reserved it as a last resort for the distant future).

This grave scientific error is repeated in the on-going National Institute of Health (NIH) study where there is no comparative or control group and only affirmation therapy is tested in clinic-registered youth (Olson, 2015). An example of an appropriate comparative therapy group would include one that was holistically treated for underlying mental health issues, engaged in regular physical activity that is enjoyable to the youth, assisted with building strong social connections, and supported by loving families who do not affirm that the youth is in the wrong body and instead only ask the youth to be open to all the possible reasons why they feel that way. “Watchful waiting” approach could be enhanced by exploring and resolving the youth’s underlying mental health issues and improving psychosocial skills, mind-body connection (i.e., engaging in physical activity), and family dynamics.

There is no mention of evaluating efficacy of affirmation therapy by Rafferty et al. Even the cited scientific publications do not evaluate efficacy of affirmative medical treatments and only offer speculation. Where is the data? Data need to show unequivocally that youth will benefit over the course of their lives from the experimental therapies.

The serious safety risks of GnRH agonists and cross-sex hormones (used alone or in combination) include cardiovascular events (venous thromboembolic disease, myocardial infarction and death), bone growth inhibition, psychological (e.g., aggression), sterilization, sexual dysfunction and potential neurological risks; all of which are scarcely mentioned in the position statement. No studies exist on the effects of these pharmaceuticals on children treated over five years and cross-sex hormones are intended for lifelong use. Long-term (>10 years) studies have demonstrated that medical transition leads to worsening of mental health and worsening of physical outcomes (Dhejne et al., 2011; Simonsen et al., 2016; Kuhn et al., 2009).

Herein lies another error in the ongoing NIH study (Olson, 2015) in that outcomes for efficacy and safety need to span past 10 years to justify the lifelong intention to medicate these youth; however, the study duration is only listed for 5 years. The idea of a honeymoon period post transition followed by a period of a return to worse mental health is supported by experienced psychiatrist, Dr. Roberto D’Angelo, who works with teen and adult trans-identifying people and their families. He has seen “that difficulties can resurface many years later and often these are the original difficulties that the person hoped transitioning would address”(gdworkinggroup.org). In contrast, Dr. Johanna Olson, one of the NIH authors, belittles the tragedy of regret by saying, “And here’s the other thing about chest surgery: If you want breasts at a later point in your life, you can go and get them” (Robbins, J, 2018).

We have used several supportive but non-affirming strategies and some of us have seen our children desist. Many of the strategies we’ve tried are reflected in the caring guidance offered by two clinical professionals, Lisa Marchiano and Sasha Ayad, who consider the full context of the youth’s experience, history, and parental input (Marchiano, 2017; Toward a more nuanced exploration, 2018).

***Summary:*** *With no clinical data and a flawed ongoing NIH study, how can the medical transition of youth who would normally desist be justified? Modern non-affirming strategies need to be evaluated.*

**Conclusion**

After you consider our concerns and engage in critical evaluation, can you stand by this position statement? How about other AAP pediatricians (those outside the committee who authored this statement) – do they stand by it? We request that you investigate their attitudes and observations by surveying them – anonymously so they aren’t targeted for non-compliance with the forces of transactivism. We request that you stand by the APP’s commitment to be “Dedicated to the health of all children” and retract this position statement while you conduct an inquiry.

If you have any doubt as to why we are anonymous, you need to look no further than Rafferty et al.’s recommendation to consider legal “support” in cases where parents do not comply with subjecting their children to experimental therapies (p 8).

Similarly, pediatricians and therapists remain silent or anonymous after witnessing the slander of those using non-affirmation approaches as demonstrated by world-renowned GD expert, Dr. Kenneth Zucker (Singal, 2016), and his long-awaited vindication (CAMH, 2018; The Canadian Press, 2018).

Please read our enclosed GC forum letter (also available at https://gendercriticalresources.com) with our four proposals and more support for our position (including further discussion on transgender suicide) with many more references that couldn’t be included here.

Copies of this letter and the enclosed have been sent to the media.

We Sincerely Thank You for Your Consideration,

Parents of Trans-identifying Youth

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