Dear Reader,

This letter provides information on the unprecedented, rapid rise in the number of pre-teens through young adults (“youth”) identifying as transgender and seeking to start lifelong medical intervention including hormone treatments and serial cosmetic surgeries.

You are receiving this letter from family members whose children have Rapid Onset Gender Dysphoria (ROGD), in which, the youth suddenly claimed they were transgender and had no gender dysphoria (GD) prior to adolescence but who had a social experience with transgender ideology in adolescence. We don’t want to see our loved ones swept up in an ideology that is inconsistent with the youth’s entire life and that is not based on high scientific standards and sufficient clinical evidence.

Please consider supporting these proposals: (1) exploring the underlying causes of GD, effectively ending “affirmation therapy,” (2) researching ROGD, (3) adding criteria to DSM-5 for GD that specifically rules-out other mental illnesses such as depression and anxiety disorders (similar to obsessive compulsive disorder criteria), and (4) requiring mental health evaluations prior to any medical treatment, effectively replacing the informed consent model for youth over the age of consent.

**Transgender-identifying people exist and deserve respect**

Some transgender-identifying adults have medically transitioned and are content with their choices. These people should be met with compassion, quality medical care, equal housing and employment opportunities, as well as given support, dignity, and respect. This letter is not about them.

**Evidence supporting a social-contagion explanation for the increase in trans-identifying youth**

Because the increase in trans youth is so new, data specifically evaluating the ROGD phenomenon is just beginning to surface (Littman 2018); thus, it is not present in the scientific literature yet. Susan Bradley, founder of Gender Identity clinic at the Toronto Center for Addiction and Mental Health (CAMH), states, “In my own practice, I have seen a good many young women displaying the phenomenon known as “rapid onset GD ,” or ROGD, which overwhelmingly affects girls.” (Bradley, 2018).

Polly Carmichael, Director of the Gender Identity Development Service at Tavistock in the United Kingdom, expressed concern that gender dysphoric youth are “finding a group” of gender questioning kids on social media such as Reddit and Tumblr. She stated that “We’d be very foolish not to acknowledge that it’s probably the case that they are caught up in something rather than it being an expression of something that has arisen from within” in a recent Association for Child and Adolescent mental health (CAMH) panel discussion (Carmichael, 2018).

The cautions from desisters (whose GD resolved) and from detransitioners (who transition to the opposite sex and later regret it and transition back) have been ignored until this past year where they’re starting to be heard in books (Anderson, 2018; Brunskell-Evans, 2018), in The Atlantic (Singal, 2018), and in Psychology Today (Sullivan, 2018). 4thwavenow.com is a website questioning the trans increase that is not religion-based or politically-based and receives 60K hits a month. Gendercriticalresources.com is a parent support group with over 1,100 members who question their youth’s claim they are transgender.

A UK organization has created a downloadable online resource pack being adopted in some UK schools which proposes “how to create a school culture of acceptance of gender non-conformity without denying biological sex” and discusses the social contagion aspect (transgender trend.com).

**The suicide argument is not supported by the evidence**

The main argument for medical treatment of youth with GD is that they will commit suicide if they are not transitioned. This hypothesis is not supported in the scientific literature. After all the personal attention, effort, and excitement associated with transitioning, there appears to be a honeymoon period of satisfaction after transition as shown in short-term studies of under 10 years in adults. However, some long-term (>10 years) studies have shown 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). There is no long-term data on outcomes for medically transitioned children.

The distorted mantra that a parent must ‘choose between medical transition or a dead child’ is based on the Williams Institute survey, which reported that 41% of the transgender and gender non-conforming (GNC) adults studied had reported an attempted suicide during their lifetime (Herman et al, 2014). The survey authors acknowledge that these “reported attempts” may be overestimated (by approximately one-half) due to faulty study design. It is an unfounded speculation to use this study result to claim that youth are more likely to attempt suicide if they don’t transition.

There is no demonstrated cause-effect relationship between not transitioning and suicide attempts. In fact, the (few) completed suicides in the US were mostly “affirmed” youth who had at least begun to socially transition. Another flaw in using this study for the suicide mantra is that we don’t know if the adults had attempted suicide before or after they socially or medically transitioned.

Furthermore, the Williams Institute survey reported a lower prevalence of suicide attempts (33%) among respondents who said their family relationships had remained strong after “coming out.” This demonstrates that family support is important and should be kept non-adversarial, but the study did not define the nature of family support. Trans-identifying youth can be loved, accepted, and supported while exploring the etiology of their gender dysphoric feelings.

**DSM criteria should require ruling-out other disorders**

It is well-established that many people identifying as transgender have mental health problems (Kaiser Permanente, 2018; Kaltiala-Heino et al 2015). Discerning between mental illness diagnoses is one of the challenges of psychiatry; thus, some diagnoses require ruling-out other mental illnesses that could better explain the clinical symptoms. This is exemplified in the diagnosis of obsessive compulsive disorder in which criteria “D” requires the psychiatrist to rule-out generalized anxiety disorder, body dysmorphic disorder, sexual urges or fantasies as in paraphilic disorders, and major depressive disorder; all of which may also be applicable to GD.

Given that these youth have many other mental health issues, shouldn’t it be compulsory to include ruling-out these disorders? It is highly plausible that a teenager who is depressed and looking for help will suddenly “discover” that they are transgender. Why does a diagnosis of GD , for which the most life-changing, long-term traumatic medical interventions are endorsed get a free pass?

**Many questions are being ignored in the media as well as in the field of gender psychology**

(1) Which came first: the mental health difficulties or the transgender-identification? (2) How are GD and other mental health issues related? and most importantly, (3) Will a youth’s mental health be improved by choosing to live a lifetime as a medically transitioned transgender individual or are we able to address underlying mental health issues and resolve the GD?

**Concerned medical doctors voice criticism of gender dysphoria (GD) treatment**

Physicians are beginning to voice their concern for the rapid and drastic medical treatments for gender dysphoric youth in scientific and medical journals (McCartney 2018; Vrouenraets et al 2017).

The purpose of this letter is to ask you to critically evaluate the trans increase. So, we ask you…

**Do you know**?

1. All 11 studies measuring duration of GDhave shown that it **is a** **transient condition in most youth**, with 60-90% of gender dysphoric youth desisting (Cantor 2017). World-renown GD expert, Dr. Zucker, has discussed the contentious criticisms of these studies (Zucker, 2018). Why are children being treated medically when most GD will resolve on its own?
2. This sudden increase in trans-identifying youth is observed worldwide (Frisén et al 2017; Aitken et al 2015; Delahunt et al 2018).
3. The US supply of transgender services is unable to meet the demand of trans-identifying youth (McFarling 2016).
4. Many youths first decide to identify as transgender after binging on transgender promotion videos and participating in transgender-focused social media and friend networks; thus, demonstrating the social contagion aspect (Littman 2017, Bradley, 2018, Marchiano, 2018).
5. Several prominent YouTube vloggers specifically promote transgender identification to kids of all ages but tend to target middle schoolers through high schoolers with a powerful brand of adolescent humor.
6. Reddit, Tumbler, Deviant Art and other online sites are known sources for where youths can find a plethora of trans promo including advice on how to threaten suicide and even stage suicide attempts to coerce parents into consenting to transgender medical treatments.
7. Whole friend groups are transitioning as clusters, whereas the chances of knowing another transgender individual in your friend group are extremely unlikely; thus, further demonstrating the social contagion aspect (prevalence rates of transgender-identifiers were estimated at 0.3% in 2011, but are estimated at 0.6% in 2017 [Hoffman, 2016]).
8. There is no biologically-based scientific proof that GD is a neurophysiological condition. It is diagnosed solely by the youth’s self-report.
9. Functional MRI studies have been limited to adults, most living opposite their birth sex for many years and who have been taking cross sex hormones for many years. Studies are conflicting and only some show minute differences that could easily be explained by personality variance (including GNC behavior), homosexual preferences and/or are the result of neuroplasticity over many years in concert with pharmacological and surgical therapies. None of the results can possibly point to neurodevelopmental deviations in utero to explain trans identification.
10. Many psychologists consider trans-identification a mental illness, but fear to say so. Transactivists and “gender doctors” try to pass it off as a benign condition, yet they desire to retain the DSM-5 classification of GD for health insurance coverage (Levine, 2017).
11. Youth under age 18 identifying as transgender may be diagnosed with GD , which is based solely on self-report of gender dysphoric feelings for only six months.
12. Youth over age 18 can walk into a Planned Parenthood clinic (Urquhart 2016, Planned Parenthood) or college healthcare clinic, sign an **informed consent** form and with absolutely no mental health screening, walk out with a supply of cross-sex hormones.
13. The mental health treatment for a youth under age 18 who is suddenly identifying as transgender is to affirm their belief. This is called **affirmation therapy**.
14. The consideration of pre-existing mental health problems or underlying causes of GD is discouraged (APA, 2015, pp. 842).
15. We know that adolescents engage in risky behavior, become fixated or stubborn, separate from their parents, demand immediate resolution to problems, are image- and body-focused, and yet, the APA recommends affirmation therapy to an out-of-the-blue claim of being transgender.
16. Affirmation therapy is poorly-defined. It can mean anything from confirming that the youth was “born in the wrong body” to engaging in “gender exploration,” which is even less well defined.
17. Even with mildest interpretation of affirmation therapy when a doctor, psychologist or other authoritarian promotes “gender exploration” over mental health exploration, we are enabling a gender fixation rather than promoting mental health, and this sends the message to the adamant youth that permission to transition is just a waiting game.
18. For a youth with no history of GD claiming to be transgender, the medical treatment options are puberty blockers, cross sex hormones, and multiple, irreversible cosmetic surgeries (APA, 2015, pp 842).
19. Youth are put on untested, unproven, off-label drugs intended to be used their entire lifetime.
20. Testosterone therapy has not been well studied in adult men or adult women (usually postmenopausal) - let alone adolescent girls on lifelong treatment. The few studies in adult women have demonstrated **several safety concerns** for females on testosterone including increased atherosclerosis, increased hypertension, increased hematocrit, decreased HDL cholesterol, sleep apnea, and potential cancer risks (Tan, 2013; Moore, 2003).
21. Studies have also shown several safety concerns for males on estrogen including venous thrombosis, increased depression, pulmonary embolism, myocardial infarction, stroke and adverse liver effects (Moore, 2003).
22. Some effects of testosterone on girls have been anecdotally reported as irreversible including lowering of the voice, male-pattern baldness, clitoral growth, and facial hair.
23. Puberty blockers are prescribed to give a young adolescent time to decide if they want to transition; however, pro-affirmation psychologist, Johanna Olson says “In my practice, I have never had anyone who was put on blockers, that did not want to pursue cross-sex hormone transition at a later point.” (Olson, 2017) If all kids on blockers eventually transition, the idea of “giving them time to decide” is completely debunked.
24. Puberty blockers followed by cross-sex hormone treatment sterilize the child. Sterilization, decreased bone mass, and unknown neurocognitive effects are known risks of puberty blocker treatment (Boghani, 2015).
25. The idea of putting the brain “on hold” with puberty blockers is the very definition of an abnormal state. Hormones affect the development and stasis of almost every bodily system and especially the brain (Barth, 2015). Normal puberty cannot simply resume after years of blocking.
26. Endocrine disorders, such as polycystic ovary syndrome (PCOS) contribute to gender identity issues (Kowalczyk et al, 2012), but with the transgender claim, these disorders go undiagnosed.
27. Youth under age 18 are having sex reassignment surgery with parental consent (Milrod, 2017).
28. Parental consent for sex reassignment surgery is *not* required at age 15 in Oregon (Springer 2015).
29. There is a high concurrence of GD and autism spectrum disorders (DeVries, et al, 2010; van der Miesen et al, 2018). The feeling of being in the wrong body might stem from feeling different than and being disconnected from others as child psychologists with GD expertise have proposed (Bradley, 2017; De Vries et al, 2018).
30. In a secondary school in the UK, 12 girls, most of whom are autistic, have all claimed to be transgender in the past 18 months (Thomas, 2018). The children brought in materials to school from Tumblr and YouTube and were given chest binders to flatten their chest at their request.
31. Laws that rightly ban “conversion therapy,” which attempts to change a person’s sexual orientation, are being expanded to include gender identity, which effectively bans a therapist from helping an individual explore the underlying causes of GD .
32. Many trans-identifying youths grow up to be homosexual adults after their GD resolves. Are we converting gay youth into “straight” transgender individuals?
33. Many children are being taught gender identity ideology in the US, UK, and Canada, despite lack of medical and scientific evidence.

Please investigate this information, **support our four proposals**, and participate in all rational debate. Please encourage research to further our understanding of ROGD and the social contagion influence. Please do so without discrimination or hatred. It is not “transphobic” to investigate explanations for the drastic rise in youth identifying as transgender.

Sincerely,

Scientists, Psychologists, Lawyers, Healthcare Workers, Teachers, and Other Professionals Who are Part of Families Devasted by the Trans Trend

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