

Appendix D – American College of Pediatricians Rejects Gender Ideology

Gender Ideology Harms Children

<https://www.acped.org/the-college-speaks/position-statements/gender-ideology-harms-children>

Originally posted March 21, 2016 – a temporary statement with references. A full statement will be published in summer 2016. Updated with Clarifications on April 6, 2016.

The American College of Pediatricians urges educators and legislators to reject all policies that condition children to accept as normal a life of chemical and surgical impersonation of the opposite sex. Facts – not ideology – determine reality.

1. Human sexuality is an objective biological binary trait: “XY” and “XX” are genetic markers of health – not genetic markers of a disorder. The norm for human design is to be conceived either male or female. Human sexuality is binary by design with the obvious purpose being the reproduction and flourishing of our species. This principle is self-evident. The exceedingly rare disorders of sex development (DSDs), including but not limited to testicular feminization and congenital adrenal hyperplasia, are all medically identifiable deviations from the sexual binary norm, and are rightly recognized as disorders of human design. Individuals with DSDs do not constitute a third sex.¹

2. No one is born with a gender. Everyone is born with a biological sex. Gender (an awareness and sense of oneself as male or female) is a sociological and psychological concept; not an objective biological one. No one is born with an awareness of themselves as male or female; this awareness develops over time and, like all developmental processes, may be derailed by a child’s subjective perceptions, relationships, and adverse experiences from infancy forward. People who identify as “feeling like the opposite sex” or “somewhere in between” do not comprise a third sex. They remain biological men or biological women.^{2,3,4}

3. A person’s belief that he or she is something they are not is, at best, a sign of confused thinking. When an otherwise healthy biological boy believes he is a girl, or an otherwise healthy biological girl believes she is a boy, an objective psychological problem exists that lies in the mind not the body, and it should be treated as such. These children suffer from gender dysphoria. Gender dysphoria (GD), formerly listed as Gender Identity Disorder (GID), is a recognized mental disorder in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-V).⁵ The psychodynamic and social learning theories of GD/GID have never been disproved.^{2,4,5}

4. Puberty is not a disease and puberty-blocking hormones can be dangerous. Reversible or not, puberty- blocking hormones induce a state of disease – the absence of puberty – and inhibit growth and fertility in a previously biologically healthy child.⁶

5. According to the DSM-V, as many as 98% of gender confused boys and 88% of gender confused girls eventually accept their biological sex after naturally passing through puberty.⁵

6. Children who use puberty blockers to impersonate the opposite sex will require cross-sex hormones in late adolescence. Cross-sex hormones (testosterone and estrogen) are associated with dangerous health risks including but not limited to high blood pressure, blood clots, stroke and cancer.^{7,8,9,10}

7. **Rates of suicide are twenty times greater among adults who use cross-sex hormones and undergo sex reassignment surgery, even in Sweden which is among the most LGBTQ – affirming countries.**¹¹ What compassionate and reasonable person would condemn young children to this fate knowing that after puberty as many as 88% of girls and 98% of boys will eventually accept reality and achieve a state of mental and physical health?

8. **Conditioning children into believing that a lifetime of chemical and surgical impersonation of the opposite sex is normal and healthful is child abuse.** Endorsing gender discordance as normal via public education and legal policies will confuse children and parents, leading more children to present to “gender clinics” where they will be given puberty-blocking drugs. This, in turn, virtually ensures that they will “choose” a lifetime of carcinogenic and otherwise toxic cross-sex hormones, and likely consider unnecessary surgical mutilation of their healthy body parts as young adults.

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For a PDF version click here: [Gender Ideology Harms](#).

CLARIFICATIONS in response to questions regarding points 3 & 5:

Regarding Point 3: “Where does the APA or DSM-V indicate that Gender Dysphoria is a mental disorder?”

The APA (American Psychiatric Association) is the author of the [Diagnostic and Statistical Manual of Mental Disorders, 5th edition](#) (DSM-V). The APA states that those distressed and impaired by their GD meet the definition of a disorder. The College is unaware of any medical literature that documents a gender dysphoric child seeking puberty blocking hormones who is not significantly distressed by the thought of passing through the normal and healthful process of puberty. From the [DSM-V fact sheet](#):

“The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition.”

“This condition causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.”

Regarding Point 5: “Where does the DSM-V list rates of resolution for Gender Dysphoria?”

On page 455 of the DSM-V under “Gender Dysphoria without a disorder of sex development” it states: “Rates of persistence of gender dysphoria from childhood into adolescence or adulthood vary. In natal males, persistence has ranged from 2.2% to 30%. In natal females, persistence has ranged from 12% to 50%.” Simple math allows one to calculate that for natal boys: resolution occurs in **as many as** $100\% - 2.2\% = 97.8\%$ (approx. 98% of gender-confused boys) Similarly, for natal girls: resolution occurs in **as many as** $100\% - 12\% = 88\%$ gender-confused girls

The bottom line: Our opponents advocate a new scientifically baseless standard of care for children with a psychological condition (GD) that would otherwise resolve after puberty for the vast majority of patients concerned. Specifically, they advise: affirmation of children's thoughts which are contrary to physical reality; the chemical castration of these children prior to puberty with GnRH agonists (puberty blockers which cause infertility, stunted growth, low bone density, and an unknown impact upon their brain development), and, finally, the permanent sterilization of these children prior to age 18 via cross-sex hormones. There is an obvious self-fulfilling nature to encouraging young GD children to impersonate the opposite sex and then institute pubertal suppression. If a boy who questions whether or not he is a boy (who is meant to grow into a man) is treated as a girl, then has his natural pubertal progression to manhood suppressed, have we not set in motion an inevitable outcome? All of his same sex peers develop into young men, his opposite sex friends develop into young women, but he remains a pre-pubertal boy. He will be left psychosocially isolated and alone. He will be left with the psychological impression that something is wrong. He will be less able to identify with his same sex peers and being male, and thus be more likely to self identify as "non-male" or female. Moreover, neuroscience reveals that the pre-frontal cortex of the brain which is responsible for judgment and risk assessment is not mature until the mid-twenties. Never has it been more scientifically clear that children and adolescents are incapable of making informed decisions regarding permanent, irreversible and life-altering medical interventions. For this reason, the College maintains it is abusive to promote this ideology, first and foremost for the well-being of the gender dysphoric children themselves, and secondly, for all of their non-gender-discordant peers, many of whom will subsequently question their own gender identity, and face violations of their right to bodily privacy and safety.

Please visit [this page](#) on the College website concerning sexuality and gender issues.

References:

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2. Zucker, Kenneth J. and Bradley Susan J. "Gender Identity and Psychosexual Disorders." *FOCUS: The Journal of Lifelong Learning in Psychiatry*. Vol. III, No. 4, Fall 2005 (598-617).
3. Whitehead, Neil W. "Is Transsexuality biologically determined?" *Triple Helix* (UK), Autumn 2000, p6-8. accessed 3/20/16 from <http://www.mygenes.co.nz/transsexuality.htm>; see also Whitehead, Neil W. "Twin Studies of Transsexuals [Reveals Discordance]" accessed 3/20/16 from http://www.mygenes.co.nz/transs_stats.htm.
4. Jeffreys, Sheila. Gender Hurts: A Feminist Analysis of the Politics of Transgenderism. Routledge, New York, 2014 (pp.1-35).
5. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Arlington, VA, American Psychiatric Association, 2013 (451-459). See page 455 re: rates of persistence of gender dysphoria.
6. Hembree, WC, et al. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2009;94:3132-3154.

7. Olson-Kennedy, J and Forcier, M. "Overview of the management of gender nonconformity in children and adolescents." UpToDate November 4, 2015. Accessed 3.20.16 from www.uptodate.com.
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11. Dhejne, C, et.al. "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden." *PLoS ONE*, 2011; 6(2). Affiliation: Department of Clinical Neuroscience, Division of Psychiatry, Karolinska Institutet, Stockholm, Sweden. Accessed 3.20.16 from <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0016885>.