



# „The gender reassignment” controversy – between affirmation and kind restraining<sup>1</sup>

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**Abstract:** The review article presents the phenomenon of transsexualism through the prism of the etiology, scale and dynamics of the phenomenon as well as the most controversial social consequences concerning „sex change” and the acceptance or non-acceptance of voluntary personal forms adopted by children and adolescents. Review of contemporary literature, analysis of positions on the issues of the so-called gender changes (gender reassignment, gender matching). The text shows the evolution of understanding of gender identity disorders in the ICD-10 and DSM-5 classifications as well as the controversy related to the tendencies depathologizing gender inconsistency in the ICD-11. Looking at the etiological issues we present an attempt of in-depth psychological analyzes as opposed to the dominant, reductive medical approach. In the text, we also recall the basic developmental regularities of children and adolescents, often overlooked in discussions on transsexualism. The basic developmental regularities of children and adolescents, often overlooked in discussions on transsexualism, were also reminded. As the review of the data shows the rapid increase in gender identity disorders in recent years, their pronouncement leads to emphasizing the growing role of pop culture influences on young people. There is also a lack of research on the use of puberty blockers in children/adolescents – their introduction appears to be an experiment with, in fact, unknown consequences. The analysis of developmental regularities, the transience of dysphoric tendencies and the lack of reliable scientific data on the use of puberty blockers and the consequences of taking hormones of the opposite sex lead to the conclusion that accepting voluntary personal forms proposed by children/teenagers is premature.

**Key words:** gender identity disorders, transsexualism, gender dysphoria, gender inconsistency

## Introduction

In recent years, a growing number of disorders concerning gender identity (formation, identification) can be observed. It is an issue whose importance is steadily growing, both because of the increasing scale of the phenomenon and the numerous social controversies it raises. A number of questions arise here, such as what should be the reaction of those around us to declarations made, for example, by young girls such as: “I think I am a boy”, “I feel male”, “I am trans”? Should they be supported or, on the contrary, rather stopped? What should be the reaction of parents, teachers or the school as an institution? A palette of different positions can be observed, from unconditional acceptance at one extreme and scepti-

cal reticence at the other. Particularly in relation to children and adolescents, these issues are becoming increasingly topical, especially in the dimension of school functioning (e.g. name changes, pronouns, access to certain toilets, cloakrooms, showers). At the same time, there is often a divergence of viewpoints between adolescents and parents (“I’ve always been like that” versus “it’s an emergency, my son/daughter has never showed such tendencies”). Controversy arises within families, in the school environment, not infrequently among medical staff – what stance should be taken towards children displaying symptoms of gender dysphoria? To affirm? To provide therapeutic interventions? To wait it out?

<sup>1</sup> Article in polish language: <https://www.stowarzyszeniefidesetratio.pl/fer/2024-1Marg.pdf>

These and similar questions and controversies were our inspiration for the topic. The most important issues related to transsexualism include, on the one hand, the often contentious issue of the aetiology of gender dysphoria in children and adolescents, and, on the other hand, the directions of therapeutic interventions and social policy that should be pursued around people identifying themselves as transsexual. This text is an attempt to present the most important issues related to transsexualism not only from a descriptive perspective, characteristic of psychopathology or developmental psychology, but also from an educational-preventive perspective that constitutes the essence of educational psychology or educational pedagogy. The first part of the article will present the representation of gender identity disorders in current classifications of mental illnesses and disorders, and reports showing a dynamic increase in the number of cases of gender dysphoria in the world. Part two covers issues of aetiology. The third part includes a reminder of the basic developmental framework necessary, in our opinion, to discuss the problem in children and adolescents, and a discussion of the specificity of gender identity disorders in developmental age. In conclusion, educational conclusions and preventive indications will be presented.

## 1. Transsexualism – gender dysphoria – gender non-conformity

In the International Classification of Diseases ICD-10 (2007), *transsexualism* (labelled F 64.0) was understood as the desire to live and be accepted as a person of the opposite sex, usually associated with a request to bring the body, by means of surgery or hormonal treatment, as close to the preferred sex as possible. This desire must persist for at least two years. There is also a separate category F 64.2 denoting *childhood gender identity disorder* applied to children before puberty, persisting for at least 6 months, during which

the child shows persistent and intense dissatisfaction with being a boy/girl and confirms a desire to be the opposite sex or proves to be the opposite sex.

The US classification of mental illnesses and disorders DSM-5 (2017), which came into force in 2013, distinguishes *gender dysphoria in adolescents and adults* (*gender identity disorder – GID*; category 302.85, equivalent to F64.0 in ICD-10), defining a marked incongruence between a person's perceived/expressed gender and their assigned gender, lasting for at least six months, associated with clinical distress or impairment in social, occupational or other important areas of functioning. There are six specific diagnostic indicators. *Gender dysphoria in children* (category 302.6, equivalent to F 64.2 in ICD-10) is defined analogously with eight specific diagnostic indicators.

There have been significant and controversial changes in the new ICD-11<sup>2</sup> classification coming into force with regard to transsexualism. Transsexualism as such has been removed from the ICD-11, which the World Health Organisation explains by wanting to combat the social stigmatisation of these people. The category F64 has been removed, and the category 17 *Conditions related to sexual health* has been introduced, and the term '*gender incongruence*' is used for people with this type of difficulty, which is defined as a persistent marked incompatibility between the sex experienced by the person and the sex assigned to them. As can be seen, in both the DSM-5 and the ICD-11, references to biological sex have been removed, the objectivity of biology has been replaced by a subjective sense of discomfort. According to Kenneth Zucker (Zucker and Duschinsky, 2016), co-author of the 'gender dysphoria' category in the DSM-5, it was intended to play a depathologising role, by emphasising in the definition the subjective incompatibility between 'ascribed sex' and 'perceived/expressed sex'.

Thus, there is a clear tendency to depathologise the phenomenon, which has long been and continues to be advocated by transgender activists affiliated

2 Officially, the new ICD-11 classification came into effect on 01/01/2022. In practice, at the time of this writing in spring 2023, the ICD-10 classification is still in use, due to the lack of a Polish translation. It is to be expected that as soon as the Polish translation appears on the WHO website, ICD-11 will replace ICD-10. Despite some differences, we use the terms transsexualism and gender dysphoria interchangeably in this text.

with the World Professional Association for Transgender Health (Bockting, 2014) and authors counted among the forerunners of a gender-fluid approach such as John Money (Money and Ehrhardt, 1972) or Harry Benjamin (1977). In Poland, proponents of this approach include a group of authors of the work *Dysphoria and Gender Nonconformity* (Grabski et al., 2020).

As Cichocki (2021) notes, the removal of transsexualism from the list of mental disorders raises serious questions. Firstly, the very existence of psychiatric diagnoses associated with negative social attitudes, such as schizophrenia or addictions, or phenomena such as obesity or anorexia, raises the rhetorical question – should psychiatric diagnoses therefore be abandoned, as in the case of transsexualism? The second doubt is related to the transfer of gender non-conformity to the health field. This means that patients who would like to treat their gender identity problems are practically deprived of this possibility. Another doubt relates to whether, as healthy persons, they should count on support from the public health service and refinancing of gender reassignment surgery (available in some countries outside Poland). Finally, in many cases transsexuals have multiple associated disorders, such as personality disorders. A Swedish study from 1973-2003 conducted on a large group of 324 transsexual patients shows that these individuals, after gender ‘correction’, have a significantly higher risk of mortality, suicidal thoughts and attempts, completed suicides and mental illness than the general population (Dhejne et al., 2011).

## 2. Complex and multifactorial aetiology – dominance of psycho-social factors

Although the aetiology of transsexual tendencies is not fully understood, we already know quite a lot about it. Despite various attempts pointing to biological or genetic factors (Coates et al, 1991; Krzystyniak and Kalota, 2019; Le Roux, 2013), everything speaks in favour of a multifactorial aetiology, including a predominantly environmental (psycho-social) one that will have a different config-

uration in each individual (Marianowicz-Szczygiel, 2021; Rabe-Jabłońska, 2012; Wallien, 2008; Zucker et al, 2012). It is possible to speak of a similarity of complex aetiological determinants analogous to the multifactorial determinants of homosexuality, while the mechanisms differentiating the formation of homosexual orientation from transsexual tendencies are not sufficiently understood (Margasiński & Białecka, 2021; Marianowicz-Szczygiel, 2021). Data from a meta-analysis of 11 studies on twins conducted by the team of Polderman et al. (2018) indicate that the median biological influence in genesis was only 36%. Detailed correlations were obtained in the studies for the co-occurrence of transsexual tendencies and high rates of psychopathology in the parents, in the child alone, relational problems within the family and problems with contact with parents, difficult relationships with peers, but also in terms of inappropriate parental reactions to the child’s gender-nonconforming behaviour (Marianowicz-Szczygiel, 2021; Zucker, 2008). A significant group of authors believe that increasingly the development of gender dysphoria is linked to psychological factors (Bell, 2020; Bonfatto & Crasnow, 2018; Evans, 2022; Patterson, 2018; Rustin, 2018). The correlations that occur can be explained in various ways, including, as root causes (e.g., autism, sexual violence, anxiety disorders, depression, psychiatric disorders), but, not knowing why, the correlations obtained are most often interpreted in only one way: co-occurring psychological disorders would be supposed to be the result of the rejection of individuals with gender dysphoria and so-called minority stress (cf. Zucker, 2019). In contrast, the exploration of the causal pathway is generally overlooked. This is noteworthy because, as Thomas and Saunders (2018) note, transsexualism can be a manifestation of broader body image disorders like BDD – *body dysmorphic disorder*, or dysmorphophobia, in DSM-5 code 300.7) or BIID (*body integrity identity disorder*), where healthy individuals want to become disabled (Lupkin, 2013; Stella, 2017).

One of the most coherent models of the emergence of transgender disorders has been put forward by Marcus Evans, a psychotherapist and for over 20 years a member of the directorate of one of the leading clinics for children and young people in the

UK, the Tavistock and Portman Clinic. According to Evans (2022), trans identity would be a defence against anxiety, depression and mental collapse, a way of coping and controlling psychological pain. The young patients (female/male type), according to the clinician, shared a common psychological profile: a fragile ego, prone to fragmentation and concrete thinking (thoughts were often experienced as physical actions), the frequent appearance of internalised grief, due to a failed relationship with an ideal object (e.g. a longed-for but possessive mother), which is projected into the body and then attacked. He also noted high levels of self-criticism and self-rejection, and a fear of being unwanted if patients are not ideal. What he believes is happening is that patients are projecting unwanted aspects of themselves into their bodies. “Rather than face the loss of the ideal object, which can threaten to collapse, the child develops the belief that the relationship with the ideal object could be restored ‘if’ this and that happened. In the case of gender dysphoria, these fantasies often take the form of: ‘If only I were a boy (or girl), it would restore my blissful relationship with my ideal object’” (Evans, 2022, p. 276). Young people, faced with the developmental challenges associated with adolescence in particular, thus retreat into psychological seclusion aimed at arresting development. Transgender identity would thus be a kind of defensive fantasy by constructing an illusory, ideal ego, into which they are often thrust by difficult circumstances and conflicting relationships (e.g. parental divorce, parental rejection). They also often have a sense of not belonging, of identity as such. The body becomes the embodiment of an undesirable part of the self, so that the development of secondary sexual characteristics during adolescence can be perceived as an unbearable trauma. However, such a defensive structure comes at a price – separation from reality (hence the ‘certainty’ of being of the opposite sex), and a strong sense of the omnipotence of one’s own thinking perpetuates the rigidity of this mental construction. If the specialist centre follows this defensive fantasy, there is a further ‘confusion of registers’, as Evans calls it, and the patient in question is left disconnected from their own body, treating it as a mannequin rather than a part of themselves with fears, feelings

and confusion. The mind and the ability to think about emotions are even often treated here as if they were an enemy to be suppressed, cut off and avoided at all costs. In his opinion, this astonishing 100 per cent certainty about one’s chosen gender identity should be a red flag and a warning sign, also the fact that the patient does not take into account the long-term medical and surgical costs. The lack of doubt so often found in transsexualism can provide a cover for deeply hidden insecurities and inner turmoil and, for example, struggles for independence and a sense of inner control over one’s life, which need to be worked through in therapy.

Nevertheless, Evans sees his role as a therapist very carefully as helping the patient to make informed decisions about their choices. Defence mechanisms (including the defensive trans identity), however, should not simply be de-emphasised as a goal of therapy in themselves, as they act as a protection of the fragile ego, for example, from overwhelming and inundating the patient with unbearable anxiety, but still it is important to look at what lies underneath these mental constructs. “The therapist needs to be mindful of the different levels of functioning of the patient. Many trans-identified people have a fixed, unexamined belief that transit will cure all their difficulties. (...) However, detransitioners have described how their belief in transit as the solution to their difficulties has broken down (...). This is when the sense of omnipotence of thinking (and feeling) is confronted with reality’ (Evans, 2022, p. 280). The psychotherapist, according to Evans, therefore helps the patient to distinguish between transference as a compromise that involves a realistic assessment of what is and is not possible, and transference as a belief that attempts to deny rather than accept reality. It thus helps to protect the patient from a situation in which short-term solutions to psychological pain carry hidden, long-term costs. He warns: “The use of omnipotent defence mechanisms, supported by the promise of what medical interventions can deliver, is a powerful and seductive psychological cocktail that makes the work of [this] psychological exploration difficult and sometimes impossible” (Evans, 2022, p. 280). Even if Evans’ concept explains only part of the cases, we have here

a compact model of the emergence of transsexual tendencies, alternative to the concept of minority stress. Consistent with Evans’ findings, the results of earlier Polish research are presented by Fajkowska-Stanik (2001). She extensively analyses the intergenerational family dynamics disturbed on many levels. Among other things, transsexual women had a low level of differentiation of the self (blurring of the boundary between the self and you and the inner self), where the emotional and intellectual systems were fused and the pseudo-self was more dominant than the solid self (p. 170), probably as an effect of being dominated by the family system (excessive closeness to the male mother and isolation from the female father). Errors in the transmission of generational gender identification up to and including the grandparents’ generation, dysfunctional family mergers and coalitions, or weak marital bonds, the desire for a male offspring and dressing in clothes of the opposite sex, but also perinatal stress were discovered in families. It was mainly the mothers who sustained masculine behaviour in their daughters.

### 3. The exponential growth of the phenomenon in recent years

The worldwide prevalence of transsexualism is estimated to be 0.001 per cent-0.002 per cent in the population (Michel et al., 2001; Urban, 2009), meaning that it is generally a rare disorder. Other authors estimate that gender non-conformity occurs in 0.001 per cent of women and 0.0033 per cent of men (after: Anderson, 2021). Nevertheless, there has been an unusually dynamic increase in GID among both adults and adolescents in recent years. Marianowicz-Szczygiel (2022) performed a meta-analysis of data from 10 countries based on enrolment criteria for specialist clinics. The data show that there has been an exponential increase in referrals to specialist clinics among children and adolescents over an

eight-year period, with a 19 700% increase in Sweden, a 7 200% increase in Italy, a 2 457% increase in the UK, a 1 750% increase in Norway, a 904% increase in the Netherlands, a 634% increase in Finland, a 12 650% increase in Australia, a 538% increase in Canada, a 275% increase in the USA and a 187% increase in New Zealand. There is no unanimity or uniform model to explain the increase. Some authors take the view that it is primarily the result of increased public awareness. This argument seems unconvincing in relation to previous estimates of the epidemiology of the phenomenon, unchallenged for decades. Marianowicz-Szczygiel, after a review of possible positions and explanations, suggests that the change in the clinical picture and the influx of predominantly adolescent girls into clinics indicate that this increase is largely driven by the influence of the liberal narrative promoting the message of freedom of gender choice<sup>3</sup>. Previous analyses suggest that the reasons for this phenomenon may be related to the influence of culture, media and social media (Littman, 2018, 2019; Pang et al., 2020) and the activism of pro-transgender activists (*GENSPECT Open Letter to the American Academy of Pediatricians*, 2022). Littman (2018, 2019), based on 256 interviews with parents of adolescents with gender dysphoria, found that most of them functioned in specific information bubbles. They were overwhelmingly influenced by the internet and social media. In conclusion, Littman proposed the concept of rapid-onset gender dysphoria (ROGD) syndrome. The conclusions reached by Littman were strongly criticised because they conflicted with the thesis of ‘free choice of gender’ or ‘the female spirit trapped in a male body’ and, on the other hand, with suggestions of ‘innate transsexualism’. However, other researchers (Hutchinson et al. 2020; Zucker, 2019) have also argued in favour of pursuing this research path. Sven Roman reports that, e.g. eating disorders, self-harm are sometimes spread through social pathways (Canadian Gender Report, 2020). In succour of Littman’s research

3 For example, in 2016, in a survey branded by the UK’s Children’s Ombudsman, children aged 13-18 were asked to describe their gender, but the examples given went beyond indicating male or female, with 25 options to choose from. The survey also asked whether “people should be free to choose their gender.” (from:) <http://wpolityce.pl/spoleczenstwo/279723-nachalne-promowanie-gender-doprowadzone-do-absurdu-13-latki-mialy-wskazac-plec-wybijajac-jedna-z-25-mozliwosci> (access: 28.01.2016). American Facebook has gone even further, with a choice of gender identity from 56 possibilities for its users. (from:) [http://wiadomosci.gazeta.pl/wiadomosci/1,114871,15462856,Facebook\\_zmienia\\_ustawienia\\_plci\\_\\_Zamiast\\_dwoch\\_opcji.html](http://wiadomosci.gazeta.pl/wiadomosci/1,114871,15462856,Facebook_zmienia_ustawienia_plci__Zamiast_dwoch_opcji.html) (access: 28.01.2016).

came Pang et al. (2020), who examined the number of thematic media publications in Australia and the UK and the reports of children and adolescents to specialist clinics between 2009 and 2016, where such strong correlations were found that the two lines almost overlap in the graph. In favour of the hypothesis of social transmission of at least some cases of gender dysphoria in adolescents is also evidenced by the stemming of the influx of underage patients to specialist clinics following a wave of public criticism of the work of such facilities in Sweden and the UK, resulting in the closure of the largest clinic, Tavistock, in 2022 (Gregory, 2022).

#### **4. Controversy over the ‘reversibility’ of the action of hormone blockers**

A huge problem, including legal ones, is the administration of so-called puberty blockers or hormones to the opposite sex, or even the performance of surgery on minors (the authors are aware of the case of a 13-year-old girl with gender dysphoria who had healthy breasts amputated in Poland). To what extent is a child able to consciously decide on irreversible changes to his or her body? What if only one parent consents and do parents even have the right to do so? Trans activists promote the concepts of ‘following the child’s declaration’ and incorporating blockers that inhibit the development of primary and secondary sexual characteristics as early as possible. This is supposed to be a preparation for full surgical transition upon reaching adulthood. In the event that the person concerned has in the meantime blundered his or her desire to ‘change sex’, it is claimed that withdrawal of the blockers will unlock normal psychosexual development, without side effects. In the WPATH Standards, the criteria for the inclusion of pubertal inhibitory hormones are categorised as fully reversible treatments. The specific criteria in para. 4 requires that “The adolescent has given informed consent and, particularly where the adolescent has not reached the age at which he or she can decide on his or her own treatment, such consent is given by

the parents or other carers and they are involved in supporting the adolescent during the treatment process” (WPATH, 2019, p. 21). This wording raises a double question – firstly, it is vague; it is not clear to which age range it refers. Secondly, it raises doubts as to how far a child/teenager, with all their emotional-cognitive limitations, can make fully informed decisions about such far-reaching medical interventions, especially as there are quite a few cases of detransition (see: Anderson, 2021; Heyer, 2020; Shrier, 2020). The introduction of a hormone therapy to block sexual maturation in children and adolescents is not grounded in clinical observations, because there are essentially none: “There is as yet no clear consensus on a hormone therapy in adolescents, as there are no long-term studies that monitor this problem” (Kaltiala-Heino et al., 2018, p. 38). The WPATH Standards acknowledge that there is a lack of studies showing the long-term developmental effects of hormone blockers, and it also acknowledges that their use can have a number of side effects. In the case of feminising therapies, side effects with increased risk levels include venous thromboembolism, cholelithiasis, elevated liver enzymes, weight gain and hypertriglyceridaemia. In the case of masculinising therapies, these include hypercythaemia (polycythemia), weight gain, acne, androgenetic alopecia, and sleep apnoea syndrome. In addition, there are a number of lower-risk complications such as cardiovascular disease, hypertension, type 2 diabetes, and cancer. Reviewing research on the effects of hormone blockers in children and adolescents, Hruz, Mayer and McHugh (2017) conclude that guidelines published by medical associations and advocacy groups give the false impression that there is an established scientific consensus on gender identity and puberty suppression. “The claim that puberty suppression in adolescents with gender dysphoria is ‘reversible’ is based on speculation rather than rigorous analysis of scientific data” (Hruz et al., 2017, p. 21) and possible side effects also include abnormal bone and muscle development, neurological problems and infertility. In a briefing paper issued by the GIDS Tavistock Clinic, it was honestly admitted de facto that children here were

subjected to a kind of experimentation: “We do not fully know how hormone blockers affect bone strength, the development of sexual organs, body shape and ultimate growth” (after High Court of Justice, 2020, para. 63). Similar doubts are raised by the Dutch authors: ‘The question is whether patients participating in this protocol can achieve normal bone density development, or whether they will end up with reduced bone density, which is associated with a high risk of osteoporosis’ (Delemarre-van de Waal and Cohen-Kettenis, 2006, p. 134).

Biggs (2019) notes that puberty blockers have not been certified as a safe and effective treatment for gender dysphoria by either their manufacturers or the relevant certification body in the UK. The programme to introduce PBs blockers in children and adolescents with gender dysphoria was introduced as an experimental programme in 2011 due to the lack of clinical trials in this area, as reported on the parent website by the GIDS Tavistock clinic itself.<sup>4</sup>

When discussing the reversibility of the effects of puberty blockers, it is worth bearing in mind the concept of so-called critical periods in human development. Critical periods, nowadays more often referred to as sensitivities or sensitivities, denote a phase of particular sensitivity to the development of certain abilities. There is an ongoing debate about their universality, but rather no one questions their occurrence, rather researchers aim to search for specific regularities (Brzezinska et al, 2016; Corominas, 2006; Shaffer, Kipp, 2015). If, due to a medical intervention, a child does not develop certain traits at the age of 12, then inducing them at the age of 18 will not be ‘reproducing the process’ because the sequence has already been disrupted. There is a natural sequence of things in which many processes occur as the body matures, and when certain phenomena happen outside of it, development does not proceed properly. Stadiality and its regularities are one of the main mechanisms of human development. With regard to psychosexual development, there is a lack of research showing the effects of introducing blockers in childhood or adolescence. As Anderson (2021,

p.167) concludes: “Doctors using puberty blockers to treat gender dysphoria without proper forethought are conducting a gigantic experiment that fails to meet even the minimum ethical standards required in other areas of medicine.”

## 5. General development framework

In considering the issue of transsexualism in children and adolescents, it is impossible to ignore the general developmental background. For most readers, these findings are certainly trivial, but it should be noted that they are rarely referred to in narrow discussions of gender identity developmental disorders, while it would seem that it should be exactly the opposite.

Adolescence (10/12-20/23) is, according to Oleszkowicz and Senejko (2016), a period of the most turbulent changes in an individual’s life, involving all spheres of functioning. During adolescence, testosterone levels in boys increase 20-fold. In girls, estrogen and progesterone levels increase 6-fold (Wolański, 2012). This has significant consequences for many spheres of life, including the emotional plane, frequent states of emotional ambivalence appear (Rosenblum, Lewis, 2004), generally with the dominance of negative feelings over positive ones (Larson, Richards, 1994), not uncommon states of adolescent depression (Modrzejewska, Bomba, 2009). Dynamic changes are taking place in the brain, its structure and functionality are changing. The density of grey matter decreases, some synapses disappear, while new synapses are formed. According to researchers (Dahl, 2004; Strauch, 2004), these processes may be associated with increased vulnerability to negative environmental influences and environmental stresses. According to Piaget’s (2012) classic concept, the development of formal thinking related to the ability to think conceptually, abstractly, the ability to synthesise and analyse, the ability to take into account multiple variables only occurs in late adolescence. Before the age of 16, the formal thinking threshold is crossed by a smaller proportion

4 <https://tavistockandpman.nhs.uk/about-us/news/stories/gender-identity-development-service-conducts-new-research> (access: 07.11.2020).

of the population (Bryant, Colman, 1995). There are a number of studies showing that during adolescence, the sense of identity is subject to frequent changes, along with numerous fluctuations in self-esteem. According to another classic, the construction of identity is among the main challenges of adolescence (Erikson, 2004). Marcia (1966), based on developmental criteria of the level of exploration and involvement distinguished: diffused identity (diffusion), mirror identity (adopted, taken over), deferred identity (moratory), achieved identity (mature) (Czyżowska, 2005; Miluska, 1996). Achieved identity, like moratory identity, does not become a reality for adolescents until late adolescence. In terms of moral development, the entry into the post conventional phase, the highest level of moral autonomy, also occurs in late adolescence (Kohlberg, 1984).

When discussing the issues of gender identity disorders in children and adolescents, these regularities should not be forgotten. But one can see a strong tendency to the contrary, related to the absolutisation of the will of patients, even when they are quite young children. Anderson (2021, p. 155-157) gives the spectacular example of Kathryn/Tyler, a girl of a few years old, who declared that she felt like a boy and, as an eight-year-old child, resolved a medical dilemma about how to implement hormone blockers. Doctors complied with the child's wishes...

## **6. Distinct dynamics of gender dysphoria in children and adolescents**

Specialists emphasize that there are two age thresholds for the manifestation of gender dysphoria, early childhood (preschool age) and adolescence (Apeiranthitou et al., 2019; Zucker, 2019). In recent times, a significant change in the clinical picture, mentioned above, is taking place here – there has been a drastic overall increase in cases of gender dysphoria, an increase in the number of adolescents relative to preschool children, and an inversion of the sex ratio (girls dominate the adolescent group). Studies also show that homosexual and transgender inclinations have at least a common origin in childhood (gender

nonconformism), the later differentiation of these phenomena has not been studied so far and may involve both qualitative and quantitative characteristics. The fact that gender nonconformism in childhood is a strong predictor of later homosexual tendencies (especially in boys) has been written about by Bailey and Zucker (1995), Beard and Bakeman (2001), Drummond et al. (2018). Thus, the lack of an adequate early response, especially from parents to gender nonconformity or gender dysphoria, can potentially lead to the formation of either transsexualism or homosexuality. In this context, the so-called gender-neutral upbringing also appears to be a contributing factor (Nieder et al., 2016; Steensma et al., 2011a), although sexual desire does not appear to be the main motive for the decision to make a so-called sex change, as the relationships obtained vary greatly (Steensma et al., 2011a).

In most children, gender dysphoria will disappear before puberty or a short time after the onset of puberty, which is also acknowledged by the authors of the WPATH Standards (2019). Estimates of researchers differ, according to Mayer and McHugh (2016) this will happen in 80-95% of children, according to others, dysphoria persisted into adulthood in only 6 to 23% of children (Bradley, Zucker, 1990; Cohen-Kettenis et al., 2011; Zucker, Bradley, 1995). The boys surveyed were more likely to identify as gay than as trans in adulthood (Bradley, Zucker, 1990). Persistence of dysphoria into adulthood, at 12-27% is reported by Drummond et al. (2008) and Wallien and Cohen-Kettenis (2008). Data derived from 12 studies compiled by Marianowicz-Szczygieł (2021) showed that 82% of children who manifested gender identity disorder in childhood no longer manifested it in their teenage years and earlier adulthood. A recent study by Singh, Bradley and Zucker (2021) confirmed the persistence of gender dysphoria symptoms in only 12.2% of the boys studied.

Let us add to this a growing number of reports of detransition in early adulthood (Anderson, 2021; Heyer, 2018; Marianowicz-Szczygieł, 2021; Shrier, 2020). Similar instability is observed in the case of homosexual tendencies in adolescents (Margasiński, Białecka, 2021; Wiczorek, 2018). The fact of such

instability calls into question the use of the term “LGBT children and youth” in general. This is because the key question here becomes, to what extent are we able to predict which children and adolescents will continue to manifest gender identity disorders (so-called *persisters*, and which will not – *desisters*)? This knowledge is only in its infancy. Valuable qualitative research (interviews), albeit with a relatively small sample of 25 adolescents, was conducted by Steensma et al, (2011b). They showed that the key age is 10-13, which is the beginning of puberty. Changes in the body associated with puberty (feminisation or masculinisation of appearance), the first crush, or the emergence of sexual desire, but also the change in the school environment (the study in the Netherlands, where the end of school occurs) played a large role here. A factor that differentiated between the two groups with persistent gender dysphoria and those where it faded was the degree of motivation, a strong aversion to one’s body favoured the perpetuation of dysphoria, the desire for only the roles typical of the desired gender worked to weaken gender dysphoria. The researchers emphasized that the differential age threshold here is a barrier of about 10 years, social transit in children before the age of 10 is therefore particularly risky. According to Steensma et al, (2013), transit before puberty shows a positive correlation to symptom stability – of the 12 boys who made a full or partial transit before puberty, 83.3%, or 10, were classified as persisters in the study, and of the 67 boys who did not make such a transit, only 13, or (19.4%) were classified from this group.

The fact that age threshold may be an indicator that can influence the trajectory of the development of gender dysphoria is also evidenced by other studies. The team of Niederet et al, (2016) studied adult transsexuals (mean age 32.8) from specialized clinics in 4 countries: The Netherlands, Belgium, Germany and Norway. 56.5% of the subjects manifested an early age of onset of gender dysphoria versus 32.4% (11.2% partially met the criteria), with a higher percentage of biological women manifesting early symptoms of gender dysphoria than men – 85.7% F/M versus 44.4% M/F. These researchers note that the developmental pathways

of gender dysphoria indicate that it varies widely and may point to different etiologies. The study did not specifically define an age for the early onset of gender dysphoria, differentiating subjects based on DSM-5 diagnostic criteria (childhood gender dysphoria or adult gender dysphoria), noting that some researchers here assume a threshold for the onset of puberty.

Thus, there are indications that early transit and affirmative messages, blocking of sexual maturation or any sowing of uncertainty about biological sex in relation to gender dysphoria, including within the framework of, for example, anti-discrimination education, can perpetuate dysphoria. The peculiarities of adolescence in relation to gender dysphoria and the exponential influx of adolescent girls to gender identity disorder clinics, described in the monitoring of epidemiology, prompts attention especially to the stage of mirror identity, when a young person uncritically adopts the norms and behaviour of the individual or group with which he or she identifies. An interesting explanation of the psychological mechanisms taking place here is given by Evans, who even talks about the cult of transference in social media, the cult of discovering one’s “authentic self,” where children are coached toward transference when they simply, and quite typically in adolescence, do not accept themselves (interview for Triggernometry, 2021). Elsewhere, Evans (2022, p. 279) writes: “Children and young adults suffering from gender dysphoria are often dominated by the fear of being unwanted if they are less than perfect. In an attempt to overcome this, they reject their family of origin and form attachments to online support groups. These groups offer concrete solutions to psychological difficulties. A website called ‘Transgender Heaven’ claims to offer a solution to detachment and confusion. ‘Feeling disconnected from your gender, feeling like you don’t fit in?’ Here is a group that understands your feelings of incongruity and confusion and can offer you an identity that can provide reassurance and a sense of belonging. As one pro-trans activist on YouTube put it, trans is the solution to feeling shitty. These pro-trans websites and lobbies are reminiscent of the defence constructs that Rosenfeld (1971) described. They claim to

provide individuals with protection from pain and confusion if they remain loyal to an online group, which is a kind of defence organization.”

Another theme that emerges in the context of sudden gender dysphoria at a tender age is, as parents report, a fascination with the world of manga and anime, which also promotes asexual role models. Manga has a 76% market share in the U.S. for comics and graphic stories and its market value is estimated at many millions of dollars, and the sector is growing rapidly (24.4 million volumes sold in 2020). Manga productions are available on leading streaming platforms (AnimeHunch, 2022). Indeed, it is quite easy to find films aimed at young people within these popular streams, which openly tell and about the trans world and are popular on the eminently youthful Tik-Tok platform<sup>5</sup>. There is even an instructional video in manga convention that talks about “sex change,” although it gives some risks, at the same time ending with a chart like this: “If you don’t like the way you look, instead of complaining all the time, you’d better get the surgery” (FermiLab manga, 2021).

## 7. Biological sex is binary

As noted earlier, defining identity disorders has been undergoing a significant and controversial evolution in recent years. An important part of these changes is the shift away from using references to biological sex and replacing the term ‘biological sex’ with ‘assigned sex.’ The concept of biological sex is being reduced from trans affirmative vocabularies, and is inconvenient because virtually every cell is sexually differentiated: “Chromosomes are present in every nucleated cell of an organism. Saying ‘Every cell has a sex’ can be justified by the presence of different sex chromosomes in it, because a female cell has two X chromosomes and a male cell has a Y chromosome with an X chromosome in its karyotype” (Midro, 2014, p. 35). Biological gender in medical and biological terms is binary and can only undergo partial

artificial modification (feminisation or masculinisation of appearance) and not immanent change. Mental identification or subjective gender identity cannot change biological layers.

In 2021, one of the American College of Paediatricians (2021) published *Sex is a Biological Trait of Medical Significance*, which provides a concise summary of biological knowledge regarding sex. Biological sex is a dimorphic, innate trait defined in terms of an organism’s biological role in reproduction. Medicine has long defined sex as a biological trait that distinguishes living beings as male or female on the basis of the sex chromosomes they possess, the presence of characteristic reproductive organs and unambiguous genitalia. In the life sciences, sex is defined according to whether an organism is designed to give or receive genetic material during the process of reproduction. Organisms that donate genetic material are classified as males; those that receive genetic material are classified as females. Human beings, like all mammals, reproduce sexually. By definition, such a reproductive system is a binary system. Primary sex determination in humans occurs at fertilization and is dependent on the two sex chromosomes of the zygote. Interventions that change a person’s appearance do not change their genetic code, often make them infertile, but do not change the way they reproduce. Therefore, gender does not change. Sexual development disorders (formerly “hermaphroditism,” “androgynousness” or “intersex”), are ailments in which normal sexual differentiation and function are disrupted or some underdevelopment has occurred. However, people with SDD do not have additional reproductive organs, with a different type of gonads or gametes. Thus, by definition, SDD individuals do not constitute additional sexes. Virtually all people with SDD are associated with impaired fertility, indicating that they are a deviation from the dominant model. Human gender is thus a binary arrangement, not an infinite spectrum as if suggested, for example, by Robert Cabaj’s definition of “gender” (Cabaj, n.d.). In fact, SDDs are rare congenital defects affecting 0.02% of the population,

5 <https://prideanime.com/17-manga-series-about-being-transgender/> (access: 08.10.2022), <https://www.anime-planet.com/users/cervintine/lists/manga-with-transgender-themes-223832> (access: 08.10.2022), <https://www.tiktok.com/discover/manga-about-gender-dysphoria?lang=en> (access: 19.02.2023)

in which either the sex organs have an ambiguous appearance, or the sexual appearance of the person does not correspond to what would be expected given that person’s sex chromosomes. The gender differences themselves are wide-ranging and include neurobiological variation, pharmacological variation (different responses to drugs), cardiovascular functioning, and functioning in sports (different performance potential and differential susceptibility to injury). ASPeds urges that modern societies, when making social policy, should not turn away from genetic findings. Genetics is the reason why a man who self-identifies as a woman remains a man, and explains why giving estrogen to a man does not turn him into a woman. While it is true, for example, that a man who uses estrogen after puberty loses muscle strength and impairs other aspects of his physiology, he does not change his genetics; he remains a man at the cellular level in all body systems. The same is true for a woman.

The facts about biological sex seem to be an inconvenient truth for proponents of the concept of treating gender as a fluid spectrum. According to Wright and Hilton (2020), biological sex is binary, and it is the duty of scientists to remind people of this basic fact. However, there is a difference between saying that there are only two biological sexes (true) and that everyone can be neatly classified as male or female (false). Gender, then, is not a “spectrum” or a “social construct.” Denying the reality of biological sex and replacing it with subjective “gender identity” in practice leads to a threat to the rights of women and homosexuals, there is chaos in medical procedures and legal chaos. The resounding text concludes with an appeal, addressed mainly to the scientific community: “The time for civility on this issue is over. Biologists and doctors must stand up for the empirical reality of biological sex. When authoritative scientific institutions ignore or deny empirical facts in the name of social accommodation, it is a blatant betrayal to the scientific community they represent. It undermines public confidence in science and is dangerously harmful to the most vulnerable” (Wright and Hilton, 2020, p. 2). In a similar vein, Nobel laureate Christiane Nüsslein-Volhard recently said, “All mammals have two sexes, and humans are

mammals. There is one sex that produces eggs, it has two X chromosomes. That’s the female. And then there is the one that produces sperm, it has an X and Y chromosome. That’s the male.” The German biologist described the desire for a sex change as wishful thinking: “This is wishful thinking. There are people who want to change their sex, but can’t do it... People keep their sex for life.” And she warns against hormone treatments: “The body can’t handle it well in the long run. Every hormone you take has side effects. Taking hormones is inherently dangerous” (Nüsslein-Volhard, 2022).

## Summary and practical notes

In discussing changes in the status of gender identity disorders, psychiatrist Lukasz Cichocki notes, “In the case of transsexualism, there is an attempt to impose on the entire environment, on all patients and professionals, the vision that there is only one possible path, a way to deal with the issue” (Cichocki, 2021, p. 90). That path is the unconditional acceptance of the child/teenager’s decision, rapid inclusion of hormone blockers, and surgical transition upon reaching adulthood. Likewise, Dora et al. (2021) advocate acceptance of the personal pronouns advocated by adolescents, arguing that their refusal may be perceived by the patient as invalidating his/her identity, and consequently contribute to increased minority stress. The commonly cited argument that refusal risks automatic suicide is not true (Heyer, 2020; Marianowicz-Szczygieł, 2021).

Anderson (2021), who has compiled the most recent experience from the US, shows that the ideology of transgender activists is highly inconsistent, at odds with logic and scientific findings, and contains a number of paradoxes. On the one hand, it is argued that the true self is something existing outside the physical body, as if in the spirit of a new Gnostic dualism, but at the same time a materialist philosophy is adhered to, in which only the real, tangible world exists. It is claimed that gender is a purely social construct, while emphasizing that a person can be “trapped” in the wrong body. The thesis of “a woman trapped in a man’s body” is absurd, who can know what it is like to be

a lion outside of a lion, for example. It is a thesis that basically speaks about the fantasy of being a woman. According to transactivists, there are no significant differences between a woman and a man, yet they invoke rigid gender stereotypes and recognize that “gender identity” is real, but its human embodiment is not. It is maintained that there is an internally hidden true self waiting to be discovered. If gender is a social construct, how can gender identity be innate and unchangeable? Can someone’s gender identity, understood as a social construct, be established by the laws of biology already in the womb? How can someone’s gender identity remain constant in the face of the fact that social constructs are changeable? And since gender identity is innate, can it be “fluid” at the same time? The challenge for activists is to propose a convincing definition of gender identity, independent of the concept of bodily sex. Thus, they are promoting a radical, expressive individualism that allows unlimited action and defining the truth as they please, while trying to force unconditional acceptance of transgender ideology. However, the attention of researchers and practitioners here should be drawn to the increasingly strong data in favour of social and media-cultural transmission of gender identity disorders among at least some adolescents.

As mentioned earlier, it is estimated that 80-95% of children with gender dysphoria grow out of it naturally, unless they are encouraged to undergo “gender reassignment” procedures. On the other hand, adolescents diagnosed with gender dysphoria have multiple concomitant disorders; 78% of adolescents surveyed with GID had previously received psychiatric treatment (Bechard et al., 2017), 52% manifested 2 or 3 other psychiatric diagnoses (M.S.C. Wallien, 2008). The co-occurrence of internalizing disorders (anxiety, depression) and/or externalizing disorders (oppositional defiant disorder) is common, and the prevalence of autism spectrum disorders is higher than in comparison groups (de Vries et al., 2010). The mechanism of spontaneous disappearance of dysphoric tendencies imposes comparisons to the specificity of homosexual tendencies in adolescents. A unique longitudinal study by Ott and his team (2011) of a sample of more than 13,000 adolescents on the adoption of

homosexual orientation showed that while at age 12 a sizable group experiences uncertainty about their sexual orientation, by age 23 the vast majority are already convinced of their heterosexuality. No educational or preventive measures were carried out on this group, so we are dealing here with natural processes. The same regularities occurred in similar studies by Savin-Williams and Ream (2007) also on an impressive sample of more than 10,000 adolescents, in the slightly earlier Remafedi (1998) or Dickson et al. (2013) in New Zealand. The research empirically confirms regularities that developmental and educational psychologists have been talking about practically forever: frequent changes in the broad identity assumed by adolescents (as well as children) are developmental regularities (cf. Margasinski and Bialecka, 2021).

Accordingly, it seems inadvisable to use altered gender pronouns, to accept the choice of toilets or locker rooms consistent with psychological identification, especially as it affects other children and school personnel (there is a well-known case of a UK child who refused to go to school because of the psychological trauma of a trans coming-out classmate). Such posts, however, should be accompanied by factual and extensive explanations of the binary of biological sex as opposed to pluralistic subjective identities. For the sake of all children, it would be advisable for biology teachers to take care to explain the gender binary in biological terms, and for physical education teachers to pay closer attention to the need for intimacy in locker rooms, for example, and to diversify sports and affirm different sporting tastes (not just soccer and other contact sports, which are difficult for delicate boys). For young people on the threshold of puberty, it would be helpful, to create a space to talk about masculinity and femininity and to be able to express any concerns about it. A fundamental issue is the awareness of parents and grandparents about the importance of encouraging behaviour consistent with biological sex, especially in young children, and how harmful it is to reject a child’s gender or dress up boys as girls and vice versa.

Overlooking the biological determinants of gender and accepting volitional personal forms also leads to a risky subjectivisation of psychopa-

thology, if we accept male personal forms in an 8-year-old, why should we not accept the conviction of a 15-year-old anorexic striving for the coveted 35 kg weight limit or the delusions of a schizophrenic patient? Such a social practice can result in questioning the legal state and, as a result, a kind of anarchisation of social life. As Anderson wryly notes in such a context, the doctor becomes merely a “syringe for hire.” One should not forget about the numerous medical mistakes and dramas of many teenagers, in whom the broader social environment (teachers, educators, doctors, therapists) accepted declarations of “sex change” and carrying out the transition, which later turned out to be a drama for these people, often undertaking detransition. The cases of Walt Heyer, Keira Bell, Cara, Max, Ria Cooper and a number of others (Anderson, 2021; Heyer, 2018; Shrier, 2020) should serve as a serious warning here. Unfortunately, these phenomena are already present in Poland as well, and in recent months we have had dramatic testimonies of people undergoing detransition, which indicates previous serious diagnostic errors.<sup>6</sup> As Lew-Starowicz recently signalled, he has 14 people in consultation in the detransition process, suggesting that the scale of the phenomenon is not small.<sup>7</sup> We know that the closed GIDS Tavistock clinic in London did not follow procedures for a comprehensive evaluation of the child’s condition, and did not complete the necessary psychological examination of minors to be sure that the child was indeed suffering from gender dysphoria (Biggs, 2019; Cass, 2022). It was against this clinic that Keira Bell, who was diagnosed with gender dysphoria at the age of 16 by the clinic’s “specialists” and quickly led to a full transition, filed a lawsuit in 2020. Today Keira is fighting to regain her femininity and warns others against similar procedures. According to media reports, a class action lawsuit is being prepared against the

Tavistock clinic of about 1,000 parents for damages related to the overly hasty introduction of puberty blockers in their children and overly hasty referral for sex reassignment surgery<sup>8</sup>.

Attributing to several-year-old children the ability to make infallible judgments is a misunderstanding. They are in the range of intelligence development in the stages of sensory-motor or preoperational development, without the ability to think conceptually, think logically, analyse, synthesise, see long-range cause-and-effect relationships. In the development of identity, they are at the level of diffused or mirror identity, also called adoptive or acquired identity, because it is most often an attempt to replicate an identity derived from an external authority. In terms of morality, the child’s world is a phase of moral heteronomy, in which rules outlined by the adult world dominate, parents and educators are treated as unquestionable authorities. It is necessary to keep in mind the unusual dynamics of this period associated with the hormonal storm and the mostly spontaneous passing of transgender feelings into adulthood. These are sufficient arguments not to introduce in the field of social policy the acceptance of subjective and volitional personal pronouns of children and adolescents, especially in the school dimension. Of great importance here would be a clear position on the part of policymakers, which is lacking. We believe that it is necessary to stand on the ground of the law, metric forms should apply in schools. However, such non-acceptance of volitional personal forms should be communicated in a climate of sympathetic understanding of the difficulties experienced by the teenager, but assertively, with a broad explanation of the formal-legal and cultural context. Children with gender dysphoria themselves deserve attention, respect, and, first and foremost, appropriate, extensive psychological diagnosis and psychotherapy of the entire family system. Prevention plays a huge role:

6 <https://www.dailymail.co.uk/news/article-11101661/Tavistock-transgender-clinic-facing-mass-legal-action-1-000-families.html>, (access: 02.02.2022).

7 <https://www.wprost.pl/kraj/11177737/prof-lew-starowicz-bije-na-alarm-czeka-nas-fala-detranzycji-problemem-min-pochopne-rozpoznania.html>, (access: 18.04.2023).

8 See the story of a well-known blogger Lukasz Sakowski *My story of reversal of sex change. Transition and detransition* <https://www.totylkoteoria.pl/tranzycja-detranzycja-zmiana-plci/> (access: 07.04.2023), <https://www.youtube.com/watch?v=81Js9QtIX1s&t=155s>, (access: 28.09.2023), Magdalena also tells her story elsewhere *Gender is in the genes, not in the self-image*, <https://marsz.info/199603-2/> (access: 17.11.2023).

building self-esteem and psychological resources, but also working on self-image, sense of masculinity and femininity and their distinctiveness. It is important to send a positive message about the child's own gender and respect for the opposite sex, proper relationships in the family, ensuring positive contact with the parent and peers of the same sex. The child's development should be monitored (from the age of 2-3) for early recognition of manifestations of gender dysphoria and appropriate and early response (reaffirming – with sensitivity to the situation – the biological sex). In an era of widespread misinformation and political correctness, this is a difficult task especially to spread reliable and comprehensive knowledge, not just superficial solutions and unconditional following of the child's feelings. Parents should pay close attention to their teenager's social media network and what the child is doing online. Any messages that undermine biological sex, membership in groups that openly encourage transgender should draw attention, although it is important to realize that the background could be, for example, body image or self-esteem issues. If parents nevertheless decide to take the experimental path of hormone intake instead of psychotherapy, it should be taken as a non-negotiable assumption that treatment of co-occurring psychiatric or psychiatric disorders should be addressed first. Any decisions with regard

to the child should be made in an interdisciplinary group of experts with the dominance of a psychologist (psychologist, psychiatrist, doctors of various specialties in cooperation with a school educator).

It is worth cautioning against the possible importation into Poland of lobbying organizations for children and young people who identify themselves as trans, such as Mermaids or GLSEN clubs, which emphasize subjective feelings and identifications, “gender expression,” and pass them off as objective facts. Communication specialist Stephanie Davis\_Arai (Boyce, 2020) emphasizes how communicatively advanced the trans affirmative narrative is – narrative, which is based on the fantasy world so attractive to the child<sup>9</sup>.

Given the dynamics of the phenomenon, the rapidly increasing scale of gender identity disorders, it seems necessary to provide the comprehensive and interdisciplinary psycho education of school and kindergarten personnel, especially psychologists and school educators, who can then provide initial assistance to children, parents and teachers. Here, in particular, it is necessary to appreciate the findings of psychology on the etiology and specifics of gender dysphoria in a developmental age, and to take care to counteract the medicalisation of the outlook exclusively in an affirmative spirit, instead of a holistic one.

## Bibliography

- American College of Pediatrics. (2021). *Sex is a Biological Trait of Medical Significance*. (From:) <https://acpeds.org/position-statements/sex-is-a-biological-trait-of-medical-significance> (access: 05.02.2022).
- Anderson, R.T. (2021). *Kiedy Harry stał się Sally. Przemyslenia w czasach transpłciowości*. Warszawa: Wydawnictwo WEI.
- AnimeHunch. (2022). *Manga Made Up 76% Of Overall Comics & Graphic Novel Sales In The US In 2021*. (From:) <https://animehunch.com/manga-made-up-76-of-overall-comics-graphic-novel-sales-in-the-us-in-2021/> (access: 06.11.2022).
- Apeiranthitou, V., Thomas, G., & Louka, P. (2019). Gender dysphoria: A critical discussion of the understanding and treatment of gender dysphoria. *Dialogues in Clinical Neuroscience & Mental Health*, 2(1), 72–80. <https://doi.org/10.26386/obrela.v2i1.110>
- Bailey, J.M., & Zucker, K.J. (1995). Childhood sex-typed behavior and sexual orientation: A conceptual analysis and quantitative review. *Developmental Psychology*, 31(1), 43–55. <https://doi.org/10.1037/0012-1649.31.1.43>
- Beard, A.J., & Bakeman, R. (2001). Boyhood Gender Nonconformity: Reported Parental Behavior and the Development of Narcissistic Issues. *Journal of Gay & Lesbian Psychotherapy*, 4(2), 81–97. [https://doi.org/10.1300/J236v04n02\\_07](https://doi.org/10.1300/J236v04n02_07)
- Bechard, M., VanderLaan, D.P., Wood, H., Wasserman, L., & Zucker, K.J. (2017). Psychosocial and Psychological Vulnerability in Adolescents with Gender Dysphoria: A “Proof of Principle” Study. *Journal of Sex & Marital Therapy*, 43(7), 678–688. <https://doi.org/10.1080/0092623X.2016.1232325>
- Bell, D. (2020). First do no harm. *The International Journal of Psychoanalysis*, 101(5), 1031-1038. <https://doi.org/10.1080/00207578.2020.1810885>

9 An example is the text: “Asexuality, neither masculinity nor femininity, but it is fantastic” <http://codziennikfeministyczny.pl/aplcioosc-ani-meskosc-ani-kobiecosc/> (access: 12.10.2018).

- Benjamin, H. (1977). *The transsexual phenomenon: All the facts about the changing of sex through hormones and surgery*. New York, N.Y.: Warner Books.
- Biggs, M. (2019a). *Tavistock's Experimentation with Puberty Blockers: Scrutinizing the Evidence*. (From:) <https://www.transgendertrend.com/tavistock-experiment-puberty-blockers/> (access: 21.08.2022).
- Bockting, W.O. (2014). Transgender identity development. (In:) D.L. Tolman & L.M. Diamond (eds.), *APA handbook of sexuality and psychology, Vol. 1: Person-based approaches*, 739-758. Washington: American Psychological Association. <https://doi.org/10.1037/14193-024>
- Bonfatto, M., & Crasnow, E. (2018). Gender/ed identities: An overview of our current work as child psychotherapists in the Gender Identity Development Service. *Journal of Child Psychotherapy*, 44(1), 29-46. <https://doi.org/10.1080/0075417X.2018.1443150>
- Bradley, S.J., & Zucker, K.J. (1990). Gender Identity Disorder and Psychosexual Problems in Children and Adolescents. *The Canadian Journal of Psychiatry*, 35(6), 477-486. <https://doi.org/10.1177/070674379003500603>
- Bryant, P., & Colman, A. (1995). *Psychologia rozwojowa*. Poznań: Wydawnictwo Zysk i S-ka.
- Brzezinska, A., Appelt, K., & Ziolkowska, B. (2016). *Psychologia rozwoju człowieka*. Sopot: Gdańskie Wydawnictwo Psychologiczne.
- Cabaj, R. (n.d.). *Lesbian, Gay, Bisexual, Transgender and people who may be questioning their sexual orientation or sexual identity (LGBTQ)*. American Psychiatric Association. (From:) <https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Treating-Diverse-Populations/Best-Practices-LGBTQ-Patients.PDF> (access: 19.02.2023).
- Canadian Gender Report. (2020). *The Swedish U-Turn on Gender Transitioning for Children*. (From:) <https://genderreport.ca/the-swedish-u-turn-on-gender-transitioning/> (access: 19.02.2023).
- Cass, H. (2022). *The Cass Review. Independent review of gender identity services for children and young people. Interim report*. (From:) <https://cass.independent-review.uk/publications/interim-report/> (access: 19.02.2023).
- Cichocki, Ł. (2021). Co z tą naszą seksualnością? (In:) B. Kmiecik (ed.), *Miedzy chromosomem a paragrafem. Transseksualizm w ujęciu prawnym, społecznym i medycznym*, 83-93. Warszawa: Wydawnictwo Instytutu Wymiaru Sprawiedliwości.
- Coates, S., Friedman, R.C., & Wolfe, S. (1991). The etiology of boyhood gender identity disorder: A model for integrating temperament, development, and psychodynamics. *Psychoanalytic Dialogues*, 1(4), 481-523. <https://doi.org/10.1080/10481889109538916>
- Cohen-Kettenis, P.T., Steensma, T.D., & de Vries, A.L. C. (2011). Treatment of Adolescents With Gender Dysphoria in the Netherlands. *Child and Adolescent Psychiatric Clinics of North America*, 20(4), 689-700. <https://doi.org/10.1016/j.chc.2011.08.001>
- Corominas, F. (2006). *Wychowywać dziś*. Ząbki: Apostolicum Wydawnictwo Księżki Pallotynów Prowincji Chrystusa Króla.
- Czyżowska, D. (2005). Style tożsamości a rozwój rozumowania moralnego jednostki. *Psychologia Rozwojowa*, 10(4), 3-82.
- Dahl, R.E. (2004). Adolescent Brain Development: A Period of Vulnerabilities and Opportunities. Keynote Address. *Annals of the New York Academy of Sciences*, 1021(1), 1-22. <https://doi.org/10.1196/annals.1308.001>
- de Vries, A.L. C., Noens, I.L. J., Cohen-Kettenis, P.T., van Berckelaer-Onnes, I.A., & Doreleijers, T.A. (2010). Autism Spectrum Disorders in Gender Dysphoric Children and Adolescents. *Journal of Autism and Developmental Disorders*, 40(8), 930-936. <https://doi.org/10.1007/s10803-010-0935-9>
- Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A.L.V., Långström, N., & Landén, M. (2011). Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. *PLoS ONE*, 6(2), e16885. <https://doi.org/10.1371/journal.pone.0016885>
- Dickson, N., van Roode, T., Cameron, C., & Paul, C. (2013). Stability and Change in Same-Sex Attraction, Experience, and Identity by Sex and Age in a New Zealand Birth Cohort. *Archives of Sexual Behavior*, 42(5), 753-763. <https://doi.org/10.1007/s10508-012-0063-z>
- Drummond, K.D., Bradley, S.J., Peterson-Badali, M., VanderLaan, D.P., & Zucker, K.J. (2018). Behavior Problems and Psychiatric Diagnoses in Girls with Gender Identity Disorder: A Follow-Up Study. *Journal of Sex & Marital Therapy*, 44(2), 172-187. <https://doi.org/10.1080/0092623X.2017.1340382>
- Drummond, K.D., Bradley, S.J., Peterson-Badali, M., & Zucker, K.J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology*, 44(1), 34-45. <https://doi.org/10.1037/0012-1649.44.1.34>
- DSM-5. (2017). *Kryteria diagnostyczne z DSM-5: Desk reference*. Wrocław: Edra Urban & Partner.
- Erikson, E.H. (2004). *Tożsamość a cykl życia*. Poznań: Zysk i S-ka.
- Evans, M. (2022). 'If only I were a boy ...': Psychotherapeutic Explorations of Transgender in Children and Adolescents. *British Journal of Psychotherapy*, 38(2), 269-285. <https://doi.org/10.1111/bjp.12733>
- Fajkowska, M. (2001). *Transseksualizm i rodzina: Przekaz pokoleniowy wzorów relacyjnych w rodzinach transseksualnych kobiet*. Warszawa: Wydawn. Instytutu Psychologii PAN, Szkoła Wyższa Psychologii Społecznej.
- Grabski, B., Mijas, M., Dora, M., & Iniewicz, G. (eds.). (2020). *Dysforia i niezgodność płciowa. Kompendium dla praktyków*. Warszawa: PZWL Wydawnictwo Lekarskie.
- Gregory, A. (2022). NHS to close Tavistock gender identity clinic for children. *The Guardian*. (From:) <https://www.theguardian.com/society/2022/jul/28/nhs-closing-down-london-gender-identity-clinic-for-children> (access: 19.02.2023).
- Heyer, W. (2018). *Trans life survivors*. United States: Walt Heyer.
- Heyer, W. (2020). *Articles of Impeachment against Sex Change Surgery*. Walter Heyer.
- Hruz, P., Mayer, L.S., & McHugh, P.R. (2017). Growing Pains. Problems with puberty suppression in treating gender dysphoria. *The New Atlantis*, 52 (Report Spring 2017). (From:) <https://www.thenewatlantis.com/publications/growing-pains> (access: 07.03.2018).
- Hutchinson, A., Midgen, M., & Spiliadis, A. (2020). In Support of Research Into Rapid-Onset Gender Dysphoria. *Archives of Sexual Behavior*, 49(1), 79-80. <https://doi.org/10.1007/s10508-019-01517-9>
- ICD-10. (2007). *Klasyfikacja zaburzeń psychicznych i zaburzeń zachowania w ICD-10: Opisy kliniczne i wskazówki diagnostyczne*. Kraków; Warszawa: Uniwersyteckie Wydawnictwo Medyczne „Vesalius”, Instytut Psychiatrii i Neurologii.
- Kaltiala-Heino, R., Bergman, H., Työläjärvä, M., & Frisen, L. (2018). Gender dysphoria in adolescence: Current perspectives. *Adolescent Health, Medicine and Therapeutics, Volume 9*, 31-41. <https://doi.org/10.2147/AHMT.S135432>
- Kohlberg, L. (1984). *The psychology of moral development: The nature and validity of moral stages* (1st ed). San Francisco: Harper & Row.
- Krzystyniak, K., & Kalota, H.M. (2019). *Gender w świetle faktów medycznych*. Warszawa: Wydawnictwo Medyk.
- Larson, R., & Richards, M. (1994). Family Emotions: Do Young Adolescents and Their Parents Experience the Same States? *Journal of Research on Adolescence*, 4(4), 567-583.
- Le Roux, N. (2013). *Gender variance in childhood/adolescence: Gender identity journeys not involving physical intervention*. <https://doi.org/10.15123/PUB.3493>

- List otwarty GENSPECT do Amerykańskiej Akademii Pediatrów. (2022). (From:) <http://onaion.org.pl/list-rodzicow-dzieci-z-zaburzeniami-plci/> (access: 19.02.2023).
- Littman, L. (2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLOS ONE*, *13*(8), 1-44. <https://doi.org/https://doi.org/10.1371/journal.pone.0202330>
- Littman, L. (2019). Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLOS ONE*, *14*(3), e0214157. <https://doi.org/10.1371/journal.pone.0214157>
- Lupkin, S. (2013). *Disorder Makes Patients Want to Be Disabled. Transabled' people want to be amputees, paraplegics, blind or deaf.* (From:) <https://abcnews.go.com/Health/body-identity-integrity-disorder-makes-patients-disabled/story?id=18423618> (access: 25.08.2022).
- Manga FermiLab (Director). (2021). *What is it like to have Gender Dysphoria? [Manga Dub]*. (From:) [https://www.youtube.com/watch?v=0YKL\\_NAnHmU](https://www.youtube.com/watch?v=0YKL_NAnHmU) (access: 03.09.2021).
- Marcia, J.E. (1966). Development and validation of ego-identity status. *Journal of Personality and Social Psychology*, *3*(5), 551-558. <https://doi.org/10.1037/h0023281>
- Margasiński, A., & Biłatecka, B. (2021). Developmental Regularities and the Issue of Adopting Homosexual Orientation by Adolescents – a Review of Research and Opinions. *Kwartalnik Naukowy Fides et Ratio*, *47*(3), 239-260. <https://doi.org/10.34766/fetr.v47i3.697>
- Marianowicz-Szczygieł, A. (2021). Zaburzenia tożsamości płciowej u dzieci i młodzieży – ujęcie psychologiczne. Geneza, czynniki ryzyka, rokowania, profilaktyka. (In:) B. Kmiecik (ed.), *Między chromosomem a paragrafem. Transseksualizm w ujęciu prawnym, społecznym i medycznym*, 93-142. Warszawa: Wydawnictwo Instytutu Wymiaru Sprawiedliwości.
- Marianowicz-Szczygieł, A. (2022). Wzrost zaburzeń tożsamości płci wśród dzieci i młodzieży – dane z 10 krajów. Możliwe wyjaśnienia, wnioski dla rodziców. *Kwartalnik Naukowy Fides et Ratio*, *49*(1), 1-20.
- Mayer, L.S., & McHugh, P.R. (2016). Sexuality and Gender. Findings from the Biological, Psychological, and Social Sciences. *The New Atlantis. Special Report*, *50*, 1-144.
- Michel, A., Mormont, C., & Legros, J. (2001). A psycho-endocrinological overview of transsexualism. *European Journal of Endocrinology*, 365-376. <https://doi.org/10.1530/eje.0.1450365>
- Miluska, J. (1996). Kulturowy kontekst procesu formowania tożsamości. *Forum Psychologiczne*, *1*(1-2), 83-96.
- Modrzejewska, R., & Bomba, J. (2009). Porównanie objawów depresji w populacji uczniów krakowskich szkół podstawowych w latach 1984 i 2001. *Psychiatria Polska*, *XLIII*(2), 167-174.
- Money, J., & Ehrhardt, A. (1972). *Man & Women, Boy & Girl*. Baltimore & London: Johns Hopkins University Press.
- Nieder, T.O., Elaut, E., Richards, C., & Dekker, A. (2016). Sexual orientation of trans adults is not linked to outcome of transition-related health care, but worth asking. *International Review of Psychiatry*, *28*(1), 103-111. <https://doi.org/10.3109/09540261.2015.1102127>
- Nusslein-Volhard, C. (2022). *Nobel Prize winner dismantles transgenderism as 'unscientific,' at odds wth fundamental biology.* (From:) <https://www.lifesitenews.com/news/nobel-prize-winner-dismantles-transgenderism-as-unscientific-at-odds-wth-fundamental-biology/> (access: 14.12.2022).
- Oleszkowicz, A., & Senejko, A. (2016). Dorastanie. (In:) J. Trempała (ed.), *Psychologia rozwoju człowieka* vol. I, 259-287. Warszawa: Wydawnictwo Naukowe PWN SA.
- Ott, M.Q., Corliss, H.L., Wypij, D., Rosario, M., & Austin, S.B. (2011). Stability and Change in Self-Reported Sexual Orientation Identity in Young People: Application of Mobility Metrics. *Archives of Sexual Behavior*, *40*(3), 519-532. <https://doi.org/10.1007/s10508-010-9691-3>
- Pang, K.C., de Graaf, N.M., Chew, D., Hoq, M., Keith, D.R., Carmichael, P., & Steensma, T.D. (2020). Association of Media Coverage of Transgender and Gender Diverse Issues With Rates of Referral of Transgender Children and Adolescents to Specialist Gender Clinics in the UK and Australia. *JAMA Network Open*, *3*(7), e2011161. <https://doi.org/10.1001/jamanetworkopen.2020.11161>
- Patterson, T. (2018). Unconscious homophobia and the rise of the transgender movement. *Psychodynamic Practice*, *24*(1), 56-59. <https://doi.org/10.1080/14753634.2017.1400740>
- Piaget, J. (2012). *Mowa i myślenie dziecka*. Warszawa: Wydawnictwo Naukowe PWN.
- Polderman, T.J. C., Kreukels, B.P. C., Irwig, M.S., Beach, L., Chan, Y.-M., Derks, E.M., ... Davis, L.K. (2018). The Biological Contributions to Gender Identity and Gender Diversity: Bringing Data to the Table. *Behavior Genetics*, *48*(2), 95-108. <https://doi.org/10.1007/s10519-018-9889-z>
- Rabe-Jabłońska, J. (2012). Zaburzenia seksualne i zaburzenia identyfikacji płciowej. (In:) J. Rybakowski, S. Pużyński, & J. Wciórka (eds.), *Psychiatria*, vol. 1-2, 531-533. Wrocław: Elsevier.
- Remafedi, G., French, S., Story, M., Resnick, M.D., & Blum, R. (1998). The relationship between suicide risk and sexual orientation: Results of a population-based study. *American Journal of Public Health*, *88*(1), 57-60. <https://doi.org/10.2105/AJPH.88.1.57>
- Rosenblum, G., Lewis, M. (2004). Emotional development in adolescence. (In:) G. Adams & M. Berzonsky (eds.), *Blackwell Handbook of Adolescence*, 270-285. Malden, MA: Blackwell Publishing.
- Rosenfeld, H. (1971). A clinical approach to the psychoanalytic theory of the life and death instincts: An investigation into the aggressive aspects of narcissism. *The International Journal of Psycho-Analysis*, *52*(2), 169-178.
- Rustin, M. (2018). Clinical commentary by Margaret Rustin, child and adolescent psychotherapist. *Journal of Child Psychotherapy*, *44*(1), 132-135. <https://doi.org/10.1080/0075417X.2018.1427773>
- Savin-Williams, R.C., & Ream, G.L. (2007). Prevalence and Stability of Sexual Orientation Components During Adolescence and Young Adulthood. *Archives of Sexual Behavior*, *36*(3), 385-394. <https://doi.org/10.1007/s10508-006-9088-5>
- Shaffer, D.R., & Kipp, K. (2015). *Psychologia rozwoju: Od dziecka do dorosłości*. Gdańsk: Harmonia Universalis.
- Shrier, A. (2020). *Irreversible damage: The transgender craze seducing our daughters*. Washington, DC: Regnery Publishing, a division of Salem Media Group.
- Singh, D., Bradley, S.J., & Zucker, K.J. (2021). A Follow-Up Study of Boys With Gender Identity Disorder. *Frontiers in Psychiatry*, *12*, 632784. <https://doi.org/10.3389/fpsy.2021.632784>
- Steensma, T.D., Biemond, R., de Boer, F., & Cohen-Kettenis, P.T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry*, *16*(4), 499-516. <https://doi.org/10.1177/1359104510378303>
- Steensma, T.D., McGuire, J.K., Kreukels, B.P. C., Beekman, A.J., & Cohen-Kettenis, P.T. (2013). Factors Associated With Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study. *Journal of the American Academy of Child & Adolescent Psychiatry*, *52*(6), 582-590. <https://doi.org/10.1016/j.jaac.2013.03.016>
- Stella, C. (Director). (2017). *Why I detransitioned and what I want medical providers to know.* (From:) <https://www.youtube.com/watch?v=Q3-r7ttcw6c> (access: 03.02.2019).

- Strauch, B. (2004). *The primal teen: What the new discoveries about the teenage brain tell us about our kids*. New York: Anchor Books. (From:) <https://archive.org/details/primalteen00barb> (access: 08.05.2019).
- Thomas, R., & Saunders, T. (2018). Gender Dysphoria. (In:) *The New Normal*, 35-54. London: Wilberforce Publication.
- Triggernometry (Director). (2021). *Transgender Clinic Whistleblower Speaks Out*. (From:) [https://www.youtube.com/watch?v=tJ\\_bD6N1zNw](https://www.youtube.com/watch?v=tJ_bD6N1zNw) (access: 05.02.2022).
- Urban, M. (2009). Transseksualizm czy urojenia zmiany płci? Uniknąć błędnej diagnozy. *Psychiatria Polska*, XLIII(6), 719-728.
- Wallien, Madeleine S.C., & Cohen-Kettenis, P.T. (2008). Psychosexual Outcome of Gender-Dysphoric Children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 47(12), 1413-1423. <https://doi.org/10.1097/CHI.0b013e31818956b9>
- Wallien, M.S.C. (2008). *Gender Dysphoria in Children: Causes and Consequences* (Vrije Universiteit). Vrije Universiteit, Amsterdam. (From:) <https://research.vu.nl/en/publications/gender-dysphoria-in-children-causes-and-consequences> (access: 04.06.2014).
- Wieczorek, B. (2018). *Homoseksualizm: Przegląd światowych analiz i badań: przyczyny, objawy, terapia, aspekty społeczne*. Warszawa: Fronda PL.
- Wolański, N. (2012). *Rozwój biologiczny człowieka: Podstawy auksoologii, gerontologii i promocji zdrowia*. Warszawa: Wydawnictwo Naukowe PWN.
- WPATH. (2019). *Standardy opieki zdrowotnej dla osób transseksualnych, transpłciowych i różnorodnych płciowo. Wersja 7*. (From:) [https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7\\_Polish.pdf?t=1573660119](https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_Polish.pdf?t=1573660119) (access: 19.02.2023).
- Wright, C., & Hilton, E. (2020). The Dangerous Denial of Sex. Transgender ideology harms women, gays – And especially feminine boys and masculine girls. *Walt Street Journal*. (From:) [https://www.wsj.com/articles/the-dangerous-denial-of-sex-11581638089?mod=opinion\\_lead\\_pos5](https://www.wsj.com/articles/the-dangerous-denial-of-sex-11581638089?mod=opinion_lead_pos5) (access: 19.02.2023).
- Zucker, Kenneth J. (2019a). Adolescents with Gender Dysphoria: Reflections on Some Contemporary Clinical and Research Issues. *Archives of Sexual Behavior*, 48(7), 1983-1992. <https://doi.org/10.1007/s10508-019-01518-8>
- Zucker, Kenneth J., & Bradley, S.J. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York: Guilford Press.
- Zucker, Kenneth J., & Duschinsky, R. (2016). Dilemmas encountered by the Sexual and Gender Identity Disorders Work Group for DSM-5: An interview with Kenneth J. Zucker. *Psychology & Sexuality*, 7(1), 23-33. <https://doi.org/10.1080/19419899.2015.1024472>
- Zucker, Kenneth J., Wood, H., Singh, D., & Bradley, S.J. (2012). A Developmental, Biopsychosocial Model for the Treatment of Children with Gender Identity Disorder. *Journal of Homosexuality*, 59(3), 369-397. <https://doi.org/10.1080/00918369.2012.653309>
- Zucker, K.J. (2008). Children with gender identity disorder: Is there a best practice? *Neuropsychiatrie de l'Enfance et de l'Adolescence*, 56(6), 358-364. <https://doi.org/10.1016/j.neurenf.2008.06.003>