

American College of Pediatrics, *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.

Continue at link below for document with footnotes.

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

Transgender Surgery Isn't the Solution

By

Paul McHugh

<http://online.wsj.com/articles/paul-mchugh-transgender-surgery-isnt-the-solution-1402615120>

June 12, 2014 7:19 p.m. ET

The government and media alliance advancing the transgender cause has gone into overdrive in recent weeks. On May 30, a U.S. Department of Health and Human Services review board ruled that Medicare can pay for the "reassignment" surgery sought by the transgendered—those who say that

they don't identify with their biological sex. Earlier last month Defense Secretary Chuck Hagel said that he was "open" to lifting a ban on transgender individuals serving in the military. Time magazine, seeing the trend, ran a cover story for its June 9 issue called "The Transgender Tipping Point: America's next civil rights frontier."

Yet policy makers and the media are doing no favors either to the public or the transgendered by treating their confusions as a right in need of defending rather than as a mental disorder that deserves understanding, treatment and prevention. This intensely felt sense of being transgendered constitutes a mental disorder in two respects. The first is that the idea of sex misalignment is simply mistaken—it does not correspond with physical reality. The second is that it can lead to grim psychological outcomes.

The transgendered suffer a disorder of "assumption" like those in other disorders familiar to psychiatrists. With the transgendered, the disordered assumption is that the individual differs from what seems given in nature—namely one's maleness or femaleness. Other kinds of disordered assumptions are held by those who suffer from anorexia and bulimia nervosa, where the assumption that departs from physical reality is the belief by the dangerously thin that they are overweight.

[Enlarge Image](#)



A man who looks into the mirror and sees himself as a woman Getty Images

With body dysmorphic disorder, an often socially crippling condition, the individual is consumed by the assumption "I'm ugly." These disorders occur in subjects who have come to believe that some of their psycho-social conflicts or problems will be resolved if they can change the way that they appear to others. Such ideas work like ruling passions in their subjects' minds and tend to be accompanied by a solipsistic argument.

For the transgendered, this argument holds that one's feeling of "gender" is a conscious, subjective sense that, being in one's mind, cannot be questioned by others. The individual often seeks not just society's tolerance of this "personal truth" but affirmation of it. Here rests the support for "transgender equality," the demands for government payment for medical and surgical treatments, and for access to all sex-based public roles and privileges.

With this argument, advocates for the transgendered have persuaded several states—including California, New Jersey and Massachusetts—to pass laws barring psychiatrists, even with parental permission, from striving to restore natural gender feelings to a transgender minor. That government

can intrude into parents' rights to seek help in guiding their children indicates how powerful these advocates have become.

How to respond? Psychiatrists obviously must challenge the solipsistic concept that what is in the mind cannot be questioned. Disorders of consciousness, after all, represent psychiatry's domain; declaring them off-limits would eliminate the field. Many will recall how, in the 1990s, an accusation of parental sex abuse of children was deemed unquestionable by the solipsists of the "recovered memory" craze.

You won't hear it from those championing transgender equality, but controlled and follow-up studies reveal fundamental problems with this movement. When children who reported transgender feelings were tracked without medical or surgical treatment at both Vanderbilt University and London's Portman Clinic, 70%-80% of them spontaneously lost those feelings. Some 25% did have persisting feelings; what differentiates those individuals remains to be discerned.

We at Johns Hopkins University—which in the 1960s was the first American medical center to venture into "sex-reassignment surgery"—launched a study in the 1970s comparing the outcomes of transgendered people who had the surgery with the outcomes of those who did not. Most of the surgically treated patients described themselves as "satisfied" by the results, but their subsequent psycho-social adjustments were no better than those who didn't have the surgery. And so at Hopkins we stopped doing sex-reassignment surgery, since producing a "satisfied" but still troubled patient seemed an inadequate reason for surgically amputating normal organs.

It now appears that our long-ago decision was a wise one. A 2011 study at the Karolinska Institute in Sweden produced the most illuminating results yet regarding the transgendered, evidence that should give advocates pause. The long-term study—up to 30 years—followed 324 people who had sex-reassignment surgery. The study revealed that beginning about 10 years after having the surgery, the transgendered began to experience increasing mental difficulties. Most shockingly, their suicide mortality rose almost 20-fold above the comparable non-transgender population. This disturbing result has as yet no explanation but probably reflects the growing sense of isolation reported by the aging transgendered after surgery. The high suicide rate certainly challenges the surgery prescription.

There are subgroups of the transgendered, and for none does "reassignment" seem apt. One group includes male prisoners like Pvt. [Bradley Manning](#), the convicted national-security leaker who now wishes to be called Chelsea. Facing long sentences and the rigors of a men's prison, they have an obvious motive for wanting to change their sex and hence their prison. Given that they committed their crimes as males, they should be punished as such; after serving their time, they will be free to reconsider their gender.

Another subgroup consists of young men and women susceptible to suggestion from "everything is normal" sex education, amplified by Internet chat groups. These are the transgender subjects most like anorexia nervosa patients: They become persuaded that seeking a drastic physical change will banish their psycho-social problems. "Diversity" counselors in their schools, rather like cult leaders, may encourage these young people to distance themselves from their families and offer advice on rebutting arguments against having transgender surgery. Treatments here must begin with removing the young person from the suggestive environment and offering a counter-message in family therapy.

Then there is the subgroup of very young, often prepubescent children who notice distinct sex roles in the culture and, exploring how they fit in, begin imitating the opposite sex. Misguided doctors at medical centers including Boston's Children's Hospital have begun trying to treat this behavior by administering puberty-delaying hormones to render later sex-change surgeries less onerous—even though the drugs stunt the children's growth and risk causing sterility. Given that close to 80% of such children would abandon their confusion and grow naturally into adult life if untreated, these medical interventions come close to child abuse. A better way to help these children: with devoted parenting.

At the heart of the problem is confusion over the nature of the transgendered. "Sex change" is biologically impossible. People who undergo sex-reassignment surgery do not change from men to women or vice versa. Rather, they become feminized men or masculinized women. Claiming that this is civil-rights matter and encouraging surgical intervention is in reality to collaborate with and promote a mental disorder.

Dr. McHugh, former psychiatrist in chief at Johns Hopkins Hospital, is the author of "Try to Remember: Psychiatry's Clash Over Meaning, Memory, and Mind" (Dana Press, 2008).

Surgical Sex

By

Paul McHugh

Why We Stopped Doing Sex Change Operations by Paul R. McHugh November 2004

<http://www.firstthings.com/article/2004/11/surgical-sex>

When the practice of sex-change surgery first emerged back in the early 1970s, I would often remind its advocating psychiatrists that with other patients, alcoholics in particular, they would quote the Serenity Prayer, "God, give me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference." Where did they get the idea that our sexual identity ("gender" was the term they preferred) as men or women was in the category of things that could be changed?

Their regular response was to show me their patients. Men (and until recently they were all men) with whom I spoke before their surgery would tell me that their bodies and sexual identities were at variance. Those I met after surgery would tell me that the surgery and hormone treatments that had made them "women" had also made them happy and contented. None of these encounters were persuasive, however. The post-surgical subjects struck me as caricatures of women. They wore high heels, copious makeup, and flamboyant clothing; they spoke about how they found themselves able to give vent to their natural inclinations for peace, domesticity, and gentleness—but their large hands, prominent Adam's apples, and thick facial features were incongruous (and would become more so as they aged). Women psychiatrists whom I sent to talk with them would intuitively see through the disguise and the exaggerated postures. "Gals know gals," one said to me, "and that's a guy."

The subjects before the surgery struck me as even more strange, as they struggled to convince anyone who might influence the decision for their surgery. First, they spent an unusual amount of time thinking and talking about sex and their sexual experiences; their sexual hungers and

adventures seemed to preoccupy them. Second, discussion of babies or children provoked little interest from them; indeed, they seemed indifferent to children. But third, and most remarkable, many of these men-who-claimed-to-be-women reported that they found women sexually attractive and that they saw themselves as “lesbians.” When I noted to their champions that their psychological leanings seemed more like those of men than of women, I would get various replies, mostly to the effect that in making such judgments I was drawing on sexual stereotypes.

Until 1975, when I became psychiatrist-in-chief at Johns Hopkins Hospital, I could usually keep my own counsel on these matters. But once I was given authority over all the practices in the psychiatry department I realized that if I were passive I would be tacitly co-opted in encouraging sex-change surgery in the very department that had originally proposed and still defended it. I decided to challenge what I considered to be a misdirection of psychiatry and to demand more information both before and after their operations.

Two issues presented themselves as targets for study. First, I wanted to test the claim that men who had undergone sex-change surgery found resolution for their many general psychological problems. Second (and this was more ambitious), I wanted to see whether male infants with ambiguous genitalia who were being surgically transformed into females and raised as girls did, as the theory (again from Hopkins) claimed, settle easily into the sexual identity that was chosen for them. These claims had generated the opinion in psychiatric circles that one’s “sex” and one’s “gender” were distinct matters, sex being genetically and hormonally determined from conception, while gender was culturally shaped by the actions of family and others during childhood.

The first issue was easier and required only that I encourage the ongoing research of a member of the faculty who was an accomplished student of human sexual behavior. The psychiatrist and psychoanalyst Jon Meyer was already developing a means of following up with adults who received sex-change operations at Hopkins in order to see how much the surgery had helped them. He found that most of the patients he tracked down some years after their surgery were contented with what they had done and that only a few regretted it. But in every other respect, they were little changed in their psychological condition. They had much the same problems with relationships, work, and emotions as before. The hope that they would emerge now from their emotional difficulties to flourish psychologically had not been fulfilled.

We saw the results as demonstrating that just as these men enjoyed cross-dressing as women before the operation so they enjoyed cross-living after it. But they were no better in their psychological integration or any easier to live with. With these facts in hand I concluded that Hopkins was fundamentally cooperating with a mental illness. We psychiatrists, I thought, would do better to concentrate on trying to fix their minds and not their genitalia.

Thanks to this research, Dr. Meyer was able to make some sense of the mental disorders that were driving this request for unusual and radical treatment. Most of the cases fell into one of two quite different groups. One group consisted of conflicted and guilt-ridden homosexual men who saw a sex-change as a way to resolve their conflicts over homosexuality by allowing them to behave sexually as females with men. The other group, mostly older men, consisted of heterosexual (and some bisexual) males who found intense sexual arousal in cross-dressing as

females. As they had grown older, they had become eager to add more verisimilitude to their costumes and either sought or had suggested to them a surgical transformation that would include breast implants, penile amputation, and pelvic reconstruction to resemble a woman.

Further study of similar subjects in the psychiatric services of the Clark Institute in Toronto identified these men by the auto-arousal they experienced in imitating sexually seductive females. Many of them imagined that their displays might be sexually arousing to onlookers, especially to females. This idea, a form of “sex in the head” (D. H. Lawrence), was what provoked their first adventure in dressing up in women’s undergarments and had eventually led them toward the surgical option. Because most of them found women to be the objects of their interest they identified themselves to the psychiatrists as lesbians. The name eventually coined in Toronto to describe this form of sexual misdirection was “autogynephilia.” Once again I concluded that to provide a surgical alteration to the body of these unfortunate people was to collaborate with a mental disorder rather than to treat it.

This information and the improved understanding of what we had been doing led us to stop prescribing sex-change operations for adults at Hopkins—much, I’m glad to say, to the relief of several of our plastic surgeons who had previously been commandeered to carry out the procedures. And with this solution to the first issue I could turn to the second—namely, the practice of surgically assigning femaleness to male newborns who at birth had malformed, sexually ambiguous genitalia and severe phallic defects. This practice, more the province of the pediatric department than of my own, was nonetheless of concern to psychiatrists because the opinions generated around these cases helped to form the view that sexual identity was a matter of cultural conditioning rather than something fundamental to the human constitution.

Several conditions, fortunately rare, can lead to the misconstruction of the genito-urinary tract during embryonic life. When such a condition occurs in a male, the easiest form of plastic surgery by far, with a view to correcting the abnormality and gaining a cosmetically satisfactory appearance, is to remove all the male parts, including the testes, and to construct from the tissues available a labial and vaginal configuration. This action provides these malformed babies with female-looking genital anatomy regardless of their genetic sex. Given the claim that the sexual identity of the child would easily follow the genital appearance if backed up by familial and cultural support, the pediatric surgeons took to constructing female-like genitalia for both females with an XX chromosome constitution and males with an XY so as to make them all look like little girls, and they were to be raised as girls by their parents.

All this was done of course with consent of the parents who, distressed by these grievous malformations in their newborns, were persuaded by the pediatric endocrinologists and consulting psychologists to accept transformational surgery for their sons. They were told that their child’s sexual identity (again his “gender”) would simply conform to environmental conditioning. If the parents consistently responded to the child as a girl now that his genital structure resembled a girl’s, he would accept that role without much travail.

This proposal presented the parents with a critical decision. The doctors increased the pressure behind the proposal by noting to the parents that a decision had to be made promptly because a child’s sexual identity settles in by about age two or three. The process of inducing the child into

the female role should start immediately, with name, birth certificate, baby paraphernalia, etc. With the surgeons ready and the physicians confident, the parents were faced with an offer difficult to refuse (although, interestingly, a few parents did refuse this advice and decided to let nature take its course).

I thought these professional opinions and the choices being pressed on the parents rested upon anecdotal evidence that was hard to verify and even harder to replicate. Despite the confidence of their advocates, they lacked substantial empirical support. I encouraged one of our resident psychiatrists, William G. Reiner (already interested in the subject because prior to his psychiatric training he had been a pediatric urologist and had witnessed the problem from the other side), to set about doing a systematic follow-up of these children—particularly the males transformed into females in infancy—so as to determine just how sexually integrated they became as adults.

The results here were even more startling than in Meyer's work. Reiner picked out for intensive study cloacal exstrophy, because it would best test the idea that cultural influence plays the foremost role in producing sexual identity. Cloacal exstrophy is an embryonic misdirection that produces a gross abnormality of pelvic anatomy such that the bladder and the genitalia are badly deformed at birth. The male penis fails to form and the bladder and urinary tract are not separated distinctly from the gastrointestinal tract. But crucial to Reiner's study is the fact that the embryonic development of these unfortunate males is not hormonally different from that of normal males. They develop within a male-typical prenatal hormonal milieu provided by their Y chromosome and by their normal testicular function. This exposes these growing embryos/fetuses to the male hormone testosterone—just like all males in their mother's womb.

Although animal research had long since shown that male sexual behavior was directly derived from this exposure to testosterone during embryonic life, this fact did not deter the pediatric practice of surgically treating male infants with this grievous anomaly by castration (amputating their testes and any vestigial male genital structures) and vaginal construction, so that they could be raised as girls. This practice had become almost universal by the mid-1970s. Such cases offered Reiner the best test of the two aspects of the doctrine underlying such treatment: (1) that humans at birth are neutral as to their sexual identity, and (2) that for humans it is the postnatal, cultural, nonhormonal influences, especially those of early childhood, that most influence their ultimate sexual identity. Males with cloacal exstrophy were regularly altered surgically to resemble females, and their parents were instructed to raise them as girls. But would the fact that they had had the full testosterone exposure in utero defeat the attempt to raise them as girls? Answers might become evident with the careful follow-up that Reiner was launching.

Before describing his results, I should note that the doctors proposing this treatment for the males with cloacal exstrophy understood and acknowledged that they were introducing a number of new and severe physical problems for these males. These infants, of course, had no ovaries, and their testes were surgically amputated, which meant that they had to receive exogenous hormones for life. They would also be denied by the same surgery any opportunity for fertility later on. One could not ask the little patient about his willingness to pay this price. These were considered by the physicians advising the parents to be acceptable burdens to bear in order to avoid distress in childhood about malformed genital structures, and it was hoped that they could follow a conflict-free direction in their maturation as girls and women.

Reiner, however, discovered that such re-engineered males were almost never comfortable as females once they became aware of themselves and the world. From the start of their active play life, they behaved spontaneously like boys and were obviously different from their sisters and other girls, enjoying rough-and-tumble games but not dolls and “playing house.” Later on, most of those individuals who learned that they were actually genetic males wished to reconstitute their lives as males (some even asked for surgical reconstruction and male hormone replacement)—and all this despite the earnest efforts by their parents to treat them as girls.

Reiner’s results, reported in the January 22, 2004, issue of the *New England Journal of Medicine*, are worth recounting. He followed up sixteen genetic males with cloacal exstrophy seen at Hopkins, of whom fourteen underwent neonatal assignment to femaleness socially, legally, and surgically. The other two parents refused the advice of the pediatricians and raised their sons as boys. Eight of the fourteen subjects assigned to be females had since declared themselves to be male. Five were living as females, and one lived with unclear sexual identity. The two raised as males had remained male. All sixteen of these people had interests that were typical of males, such as hunting, ice hockey, karate, and bobsledding. Reiner concluded from this work that the sexual identity followed the genetic constitution. Male-type tendencies (vigorous play, sexual arousal by females, and physical aggressiveness) followed the testosterone-rich intrauterine fetal development of the people he studied, regardless of efforts to socialize them as females after birth. Having looked at the Reiner and Meyer studies, we in the Johns Hopkins Psychiatry Department eventually concluded that human sexual identity is mostly built into our constitution by the genes we inherit and the embryogenesis we undergo. Male hormones sexualize the brain and the mind. Sexual dysphoria—a sense of disquiet in one’s sexual role—naturally occurs amongst those rare males who are raised as females in an effort to correct an infantile genital structural problem. A seemingly similar disquiet can be socially induced in apparently constitutionally normal males, in association with (and presumably prompted by) serious behavioral aberrations, amongst which are conflicted homosexual orientations and the remarkable male deviation now called autogynephilia.

Quite clearly, then, we psychiatrists should work to discourage those adults who seek surgical sex reassignment. When Hopkins announced that it would stop doing these procedures in adults with sexual dysphoria, many other hospitals followed suit, but some medical centers still carry out this surgery. Thailand has several centers that do the surgery “no questions asked” for anyone with the money to pay for it and the means to travel to Thailand. I am disappointed but not surprised by this, given that some surgeons and medical centers can be persuaded to carry out almost any kind of surgery when pressed by patients with sexual deviations, especially if those patients find a psychiatrist to vouch for them. The most astonishing example is the surgeon in England who is prepared to amputate the legs of patients who claim to find sexual excitement in gazing at and exhibiting stumps of amputated legs. At any rate, we at Hopkins hold that official psychiatry has good evidence to argue against this kind of treatment and should begin to close down the practice everywhere.

For children with birth defects the most rational approach at this moment is to correct promptly any of the major urological defects they face, but to postpone any decision about sexual identity until much later, while raising the child according to its genetic sex. Medical caretakers and parents can strive to make the child aware that aspects of sexual identity will emerge as he or she

grows. Settling on what to do about it should await maturation and the child's appreciation of his or her own identity.

Proper care, including good parenting, means helping the child through the medical and social difficulties presented by the genital anatomy but in the process protecting what tissues can be retained, in particular the gonads. This effort must continue to the point where the child can see the problem of a life role more clearly as a sexually differentiated individual emerges from within. Then as the young person gains a sense of responsibility for the result, he or she can be helped through any surgical constructions that are desired. Genuine informed consent derives only from the person who is going to live with the outcome and cannot rest upon the decisions of others who believe they "know best."

How are these ideas now being received? I think tolerably well. The "transgender" activists (now often allied with gay liberation movements) still argue that their members are entitled to whatever surgery they want, and they still claim that their sexual dysphoria represents a true conception of their sexual identity. They have made some protests against the diagnosis of autogynephilia as a mechanism to generate demands for sex-change operations, but they have offered little evidence to refute the diagnosis. Psychiatrists are taking better sexual histories from those requesting sex-change and are discovering more examples of this strange male exhibitionist proclivity.

Much of the enthusiasm for the quick-fix approach to birth defects expired when the anecdotal evidence about the much-publicized case of a male twin raised as a girl proved to be bogus. The psychologist in charge hid, by actually misreporting, the news that the boy, despite the efforts of his parents to treat him and raise him as a girl, had constantly challenged their treatment of him, ultimately found out about the deception, and restored himself as a male. Sadly, he carried an additional diagnosis of major depression and ultimately committed suicide.

I think the issue of sex-change for males is no longer one in which much can be said for the other side. But I have learned from the experience that the toughest challenge is trying to gain agreement to seek empirical evidence for opinions about sex and sexual behavior, even when the opinions seem on their face unreasonable. One might expect that those who claim that sexual identity has no biological or physical basis would bring forth more evidence to persuade others. But as I've learned, there is a deep prejudice in favor of the idea that nature is totally malleable.

Without any fixed position on what is given in human nature, any manipulation of it can be defended as legitimate. A practice that appears to give people what they want—and what some of them are prepared to clamor for—turns out to be difficult to combat with ordinary professional experience and wisdom. Even controlled trials or careful follow-up studies to ensure that the practice itself is not damaging are often resisted and the results rejected.

I have witnessed a great deal of damage from sex-reassignment. The children transformed from their male constitution into female roles suffered prolonged distress and misery as they sensed their natural attitudes. Their parents usually lived with guilt over their decisions—second-guessing themselves and somewhat ashamed of the fabrication, both surgical and social, they had imposed on their sons. As for the adults who came to us claiming to have discovered their "true"

sexual identity and to have heard about sex-change operations, we psychiatrists have been distracted from studying the causes and natures of their mental misdirections by preparing them for surgery and for a life in the other sex. We have wasted scientific and technical resources and damaged our professional credibility by collaborating with madness rather than trying to study, cure, and ultimately prevent it.

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[Why I Voted Against the Transgender Bathroom Policy](#)

The Montesano City Council recently voted to pass a transgender policy allowing children to use the bathroom of their preferred gender rather than their biological gender. The Montesano School Superintendent, who supported the policy, sent a video to the school board members featuring a deaf, transgender child the hope of encouraging them to support the new policy. The video can be found below. Caleb Backholm is a member of the Montesano School Board and wrote this response to the Superintendent. Caleb Backholm is also the brother of FPIW executive director Joseph Backholm.

<http://www.fpiw.org/blog/2015/07/01/why-i-voted-against-the-transgender-bathroom-policy/>