Standards and Guidelines of the Association of Christian Psychologists in Poland for the Diagnosis and Therapy of Children and Adolescents with Gender Identity Issues

Project for public consultation

Association of Christian Psychologists
in Poland

Citation:

Marianowicz-Szczygiel A., Margasinski A., Smyczynska J., Pietruszewski K., Próchniewicz J., Wozinska K., Chochel K., Białecka B., Kolodziejczyk A. et all (2024). Standards and Guidelines of the Association of Christian Psychologists in Poland for the Diagnosis and Therapy of Children and Adolescents with Gender Identity Issues. Association of Christian Psychologists in Poland, Warsaw.

OPINIONS ABOUT THE DOCUMENT

"The Standards and Guidelines of the Association of Christian Psychologists in Poland for the Diagnosis and Therapy of Children and Adolescents with Gender Identity Issues" is a comprehensive anthropologically and scientifically sound document grounded in the ancient medical ethics principle of first do no harm. At least seven independent systematic reviews of the world's scientific literature have concluded that affirming gender incongruence in youth is, at best experimental, and can result in significant irreversible harm. The international community owes a debt of gratitude to this organization for courageously producing these long overdue standards and guidelines for the optimal and ethical care of youth with gender identity issues.

Michelle A. Cretella, M.D.

Co-Chair, Adolescent Sexuality Council of the American College of Pediatricians

The "The Standards and Guidelines of the Association of Christian Psychologists in Poland for the Diagnosis and Therapy of Children and Adolescents with Gender Identity Issues" thoroughly addresses the anthropology of human sexuality and the aetiology of Gender Identity Issues. Its recommendations for dealing with children and adolescents with Gender Identity Disorders is meticulous and methodical. In the long run, following the recommendations will also reveal prevalence rates for each aspect of test and outcomes, enabling simpler Guidelines that is underpinned by the knowledge of this document. This would be beneficial for many communities around the world.

Bryan Shen
Registered Professional Counsellor, South East Asia Region.

The question of what care should be given to children and adolescents experiencing gender confusion has been a controversial medical, social, political and legal issue throughout all Western Countries. Too often good clinical practice in Western nations has been hijacked by social and political ideologies. The Association of Christian Psychologists in Poland has produced a sensible and evidence-based document that provides a coherent and comprehensive survey of anthropology, research, clinical practice foundations and social policy analysis which provide a suitable foundation for a sensible standard for best practice in diagnosis and therapy. This document – "The Standards and Guidelines of the Association of Christian Psychologists in Poland for the Diagnosis and Therapy of Children and Adolescents with Gender Identity Issues" - is a fantastic resource that sets out common sense and evidence-based standards for care of children experiencing gender confusion. It is to be commended.

John Steenhof
Principal Lawyer of the Human Rights Law Alliance, Australia

This "Standards and Guidelines" are truly excellent! Based on multiple systematic research reviews and clinical experience from competent health authorities, they are what every standard of care for children and adolescents who have gender concerns should look like! And at last, we have one from a Christian perspective!

Laura Haynes, Ph.D., Executive Board Member, U.S.A. Country Representative, and Chair of the Science and Research Council, International Foundation for Therapeutic and Counselling Choice, USA

(We would especially like to thank Dr. Laura Haynes for her help in editing this document)

With the enormous increase in young people identifying as transgender and/or expressing distress, what is the best response? What constitutes genuine, holistic care for the child? Based on extensive research and recent evidence reviews from numerous European countries and U.S. states, SPCH Standards 2023 answers these questions in detail. The Standards provide an excellent and much needed protocol for doctors and therapists in Poland, providing a comprehensive rebuttal and grounded alternative to the gender affirming model.."

Amy E. Hamilton, Ph.D.,
Research Associate, University of Texas-Austin, USA

Starting premature gender reassignment is like playing Russian roulette with 5 out of 6 bullets in the barrel. It's a madness that will have irreversible consequences for the adolescent. The caution suggested by ACPP is a must for everyone on this subject. In France, gender ideologists have seized power in the national education system, and feminist and LGBT associations are indoctrinating children and teenagers, who are disturbed (especially boys) and even deconstructed in their construction as future men. To date, the future consequences are incalculable. Even the Chinese authorities are worried that the feminization of boys could endanger their civilization. Gender theory is utter nonsense, invalidated by science and studies and observations made since the dawn of time. It is criminal because it leads young people to believe that they can choose their sex as they please.

Jean-Paul Benglia
Specialist and lecturer on gender theory and its dangers for children and teenagers, France

This document is long-awaited and extremely needed by helping professionals, teachers and parents that often feel confused when it comes to transgender issues. The guidelines are especially valuable because of their strong support by scientific data and grounded studies. May God bless this important beginning!

Kristina Malysheva, psychologist, Ukraine

The range, depth, scope and clarity of the SPCh Standards 2023 is stunning. It effectively unpacks, explains and engages the many complex anthropological, sociological, legal, historical, medical and scientific aspects around gender identity issues. It rightly sounds the alarm on the various 'unknowns' and 'unknowables' (at present) which every trans youngster ought to be informed of. Its compassion for all involved is apparent and its recommendations moving forward are positive and practical. Though very thoroughly researched and written by professionals, it is accessible to the general public, especially parents whose youngsters now assure them they have been born in 'the wrong body' and need a 'sex change'.

Lisa Severine Nolland MA MCS PhD (University of Bristol); CEO, Marriage, Sex and Culture Group, London UK

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Standards and Guidelines of the Association of Christian Psychologists in Poland for the Diagnosis and Therapy of Children and Adolescents with Gender Identity Issues

Project for public consultation[1]

This document, called 'SPCh Standards 2024' for short, was created in several stages starting in early 2023. Its shape is the result of the work of several experts drawing on international clinical experience and scientific research: psychologists, psychotherapists (including child and adolescent psychotherapists, family therapists and addiction therapists), sexologists and physicians (specializing in family medicine, psychiatry, paediatric endocrinology, gynecology and maternity). This is the first version of this document, extremely needed not only in Poland, filling an important gap in professional knowledge[2]*.*

I. ANTHROPOLOGICAL FRAMEWORK

Every human being is a unique individual, comprising a unity of physical, psychological, and spiritual dimensions which should not be treated separately. Everyone fully deserves respect and possesses the intellect and freedom to pursue their individual purpose in life, which includes freedom to make optimal life choices. However, one is not a lone island; one lives within a society, interconnected through bonds of interdependence.

A person's gender is not a 'state of mind', but a binary biological reality, defined by the capacity for sexual reproduction[3]. Every cell in our body[4] is sexually differentiated. For this reason, biological sex can only undergo partial, artificial modification (feminization or masculinisation of appearance) and cannot change (hence there is no 'sex change'.).

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1 The document is completed and ready for implementation, and the status "project for public consultation" refers to the opening for public discussion, after which a revised version will be published.

2 So far, only gender-affirming standards have been published in Poland (see the distinction below) and concerning adults: 1. the Polish Sexological Society and 2. in the journal "Endokrynologia Polska" (however, suggesting psychotherapy as an alternative in the case of both adults, as well as children, p.413) - sources: 1. Grabski B. et all (2021). Zalecenia Polskiego Towarzystwa Seksuologicznego dotyczące opieki nad zdrowiem dorosłych osób transpłciowych - stanowisko panelu ekspertów. Psychiatr. Pol. 55(3), pp.701–708 DOI: https://doi.org/10.12740/PP/OnlineFirst/125785; 2. Mędraś M., Józków P. (2010). Transseksualizm — aspekty diagnostyczne i terapeutyczne. Endokrynologia Polska, 61, pp. 412-416. https://journals.viamedica.pl/endokrynologia_polska/article/viewFile/25317/20146

3 Sex is clearly biological, then (as so called "gender") secondarily psychological, secondarily cultural, secondarily social (in Polish "sex" and "gender" are united into one word).

4 Exactly "every nucleated somatic cell", which constitutes the vast majority of cells, e..g. erythrocytes (red blood cells) in humans do not have nuclei.

Psychological subjective gender identification (multi-variant and unstable)[5] cannot alter biology, as subjective perception does not have the power to change reality ('the body is me')[6]. Individuals popularly referred to as "intersex", those suffering from disorders of sexual development/differences of sexual development (DSD), do not represent a 'third gender', as they do not have an alternative reproductive pathway. Thus, this disorder is a deviation from the common pattern.

II. SCIENTIFIC AND PROFESSIONAL FOUNDATIONS

These professional standards and diagnostic-therapeutic guidelines, based on evidence-based knowledge, primarily, but not exclusively, arise from the following reviews of scientific literature, international documents, and professional guidelines:

1. Report from the Swedish state agency SBU from December 2019, commissioned by the Swedish government (SBU 2019/427)[7],
2. An independent British report, known as the "Cass review", commissioned by the National Health Service in the UK - NHS England (2022)[8],
3. Two reports from NICE (The National Institute for Health and Care Excellence) in the UK, commissioned by the National Health Service in the UK - NHS England (14-10-2020)[9] and (21-10-2020)[10],
4. International Federation of Therapeutic and Counselling Choice (9-03-2023) "

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5 Instytut „Ona i On". 235 orientacji płciowych i seksualnych. http://onaion.org.pl/2020/08/18/235-orientacji--plciowych-i-seksualnych/

6 For example, genes or the morphology of the skeletal system do not change in the so-called medical transition. Departure from biological reality leads to absurdities and paradoxes, such as the exemplary, a changed definition of femininity based on wishful thinking and the apparent omnipotence of thinking: "A woman is a universal existential state defined by submission to someone else's desires" (Andrea Lonh Chu za Shier A.[2023]. Nieodwracalna krzywda. Kraków: Dystrybucja AA, p.229; translation of the quote from Polish.

7 Swedish Agency for Health Technology Assessment and Assessment of Social Services (20-12-2019). Gender dysphoria in children and adolescents: an inventory of the literature. A systematic scoping review. https://www.sbu.se/en/publications/sbu-bereder/gender-dysphoria-in-children-and-adolescents-an-inventory-of-the-literature/

8 Cass, H. (February 2022). The Cass Review. Independent review of gender identity services for children and young people: Interim report https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim-Report-Final-Web-Accessible.pdf

9 N.I.C.E. (14-10-2020). Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria: https://cass.independent-review.uk/wp-content/uploads/2022/09/20220726_Evidence-review_GnRH-analogues_For-upload_Final.pdf

10 N.I.C.E. (21-1-2020). Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria. https://cass.independent-review.uk/wp-content/uploads/2022/09/20220726_Evidence-review_Gender-affirming-hormones_For-upload_Final.pdf

IFTCC Principles for Approaches to Transgender Treatments"[11],

5. Judgment of the Supreme Court in the UK in the case of Quincy Bell and Mrs. A. versus The Tavistock and Portman NHS Foundation Trust dated 1-12-2020, Case No: CO/60/2020[12],
6. Position of the French National Academy of Medicine dated 25-02-2022[13],
7. Report and statement of The Florida Department of Health[14] [15],
8. Review "Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria", The Linacre Quarterly[16],
9. Position of the American College of Paediatricians [17] [18],
10. Literature review by the Society of Evidence-Based Gender Medicine (SEGM)[19],
11. Position of the governmental agency COHERE Finland (16-06-2020)[20],
12. Guidelines of Gender Exploratory Therapy Association (2022)[21]
13. Guidelines of National Association of Practising Psychiatrists, Australia (18.03.2022)[22]

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11 IFTCC (9-03-2023). IFTCC Principles for Approaches to Transgender Treatments. https://iftcc.org/standards/;Polish translation: http://onaion.org.pl/2023/06/30/miedzynarodowe-wytyczne-w-kwestiach-transgenderowych/

12 Q. Bell i Mrs A. versus Tavistock and Portman NHS Foundation Trust https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf

13 French National Academy of Medicine (25-02-2022). Medicine and gender transidentity in children and adolescents, https://www.academie-medecine.fr/la-medecine-face-a-la-transidentite-de-genre-chez-les-enfants-et-les-adolescents/?lang=en

14 The Florida Department of Health (20-04-2022). Treatment of Gender Dysphoria for Children and Adolescents. https://www.floridahealth.gov/_documents/newsroom/press-releases/2022/04/20220420-gender-dysphoria-guidance.pdf

15 Cantor J.M. (17-05-2022). Attachment D: Report submitted to the Florida Agency for Healthcare Administration. In Florida Agency for Healthcare Administration (June 2022). Florida Medicaid Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria.

16 Hruz P.W. (20-09-2019). Deficiencies in scientific evidence for medical management of gender dysphoria. *The Linacre Quaterly,* vol. 87 (1), https://doi.org/10.1177/0024363919873762

17 American College of Pediatricians (November 2018). Gender dysphoria in children. https://acpeds.org/position-statements/gender-dysphoria-in-children

18 American College of Pediatricians (March 2021). Sex is a biological trait of medical significance. https://acpeds.org/position-statements/sex-is-a-biological-trait-of-medical-significance

19 SEGM, "Studies", "compendium of literature to highlight our position of concern over the proliferation of hormonal and surgical 'gender-affirmative' interventions for gender dysphoric youth" https://segm.org/studies

20 Council for Choices in Health Care in Finland (16-06-2020). Medical treatment methods for dysphoria associated with variations in gender identity in minors – recommendation. https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en.pdf/aaf9a6e7-b970-9de9-165c-abedfae46f2e/Summary_minors_en.pdf

21 Gender Exploratory Therapy Association (2022). A Clinical Guide for Therapists Working with Gender-Questioning Youth Version 1. https://www.genderexploratory.com/wp-content/uploads/2022/12/GETA_ClinicalGuide_2022.pdf

22 National Association of Practicing Psychiatrists (18-03-2022). Managing gender dysphoria/incongruence in young people: a guide for health practitioners.

14. Position of the Royal Australian and New Zealand College of Psychiatrists - August 2021[23],
15. Position of the Norwegian Healthcare Investigation Board - UKOM from March 2023[24],
16. Open letter from Genspect and 3558 parents to members of the American Academy of Paediatrics (Genspect 18-02-2022)[25],
17. Model used in the Gender Identity Service at the Centre in Canada[26],
18. Article "Freedom to think" by Marcus Evans (2020)[27],
19. Data from health registers in Denmark[28],
20. Thematic literature review on the STATSFORGENDER.ORG website[29].

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https://napp.org.au/2022/03/managing-gender-dysphoria-incongruence-in-young-people-a-guide-for-health-practitioners-2/

23 Position statement no. 103: „Recognising and addressing the mental health needs of people experiencing Gender Dysphoria /Gender Incongruence". https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/gender-dysphoria

24 Original source: UKOM (9-03-2023). Pasientsikkerhet for barn og unge med kjřnnsinkongruens. https://ukom.no/rapporter/pasientsikkerhet-for-barn-og-unge-medkjonnsinkongruens/sammendrag ; Overview in English: Jenifer Block (23-03-2023). Norway's guidance on paediatric gender treatment is unsafe, says review. *BMJ* 2023 (380), p.697 http://dx.doi.org/10.1136/bmj.p697 https://www.bmj.com/content/bmj/380/bmj.p697.full.pdf

25 Genspect (18-06-2022). An Open Letter to the American Academy of Pediatrics – Genspect. Polish translation on the website "She and He" Institute: http://onaion.org.pl/list-rodzicow-dzieci-z-zaburzeniami-plci/

26 Zucker et all (2012). A developmental, biopsychosocial model for the treatment of children with gender identity disorder. *Journal of Homosexuality* 59 (3), pp. 369-397, DOI: 10.1080/00918369.2012.653309

27 Evans M. (2020). Freedom to think: the need for thorough assessment and treatment of gender dysphoric children. *BJPsych Bulletin*, pp. 1-5. https://doi.org/10.1192/bjb.2020.72 https://www.cambridge.org/core/journals/bjpsych-bulletin/article/freedom-to-think-the-need-for-thorough-assessment-and-treatment-of-gender-dysphoric-children/F4B7F5CAFC0D0BE9FF3C7886BA6E904B

28 Glintborg D., Mřller J.J.K., Rubin K.H., Lidegaard O., T'Sjoen G., Larsen M.L.J.O., Hilden M., Andersen M.S. (2023). Gender-affirming treatment and mental health diagnoses in Danish transgender persons: A nationwide register-based cohort study. *European Journal of Endocrinology*, 189, pp.336-345. https://doi.org/10.1093/ejendo/lvad119; Por. Glintborg D., Rubin K., Kristensen S., Lidegaard Ø., T'Sjoen G., Hilden, M., Andersen M. (2022). Gender affirming hormonal treatment in Danish transgender persons. A nationwide register-based study. Andrology. 10 (3) DOI: 10.1111/andr.13181

29 STATSFORGENDER.ORG, "Gender at your fingertips".

21. Based on Polish publications[30] [31] [32] [33] [34]
22. Based on data regarding detransition[35] [36] [37] [38] [39] [40] [41] [42] [43]
23. And 'Review of 22 standards and models for assisting children and adolescents with gender identity disorders - recommendations for the Polish model' (Marianowicz-Szczygieł A. *in press)*.

The assumptions of leading guidelines in the affirming trend (e.g., the Dutch Protocol[44],

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30 Kmieciak B, Sobczyk P. (eds). *Między chromosomem, a paragrafem. Transseksualizm w ujęciu prawno- społeczno-medycznym*, pp. 93-142, Warszawa: Wydawnictwo Instytutu Wymiaru Sprawiedliwości

31 Fajkowska, M. (2001). Transseksualizm i rodzina: Przekaz pokoleniowy wzorów relacyjnych w rodzinach transseksualnych kobiet. Wydawn. Instytutu Psychologii PAN, Szkoła Wyższa Psychologii Społecznej

32 Marianowicz-Szczygieł, A. (2022).). Rise of gender identity disorders among children and adolescents- data from 10 countries. Kwartalnik Naukowy Fides Et Ratio, 49(1), pp.122-141. https://doi.org/10.34766/fetr.v49i1.1060 https://doi.org/10.34766/fetr.v49i1.1060, English text: https://fidesetratio.com.pl/ojs/index.php/FetR/article/view/1060/724 Polish Text: https://www.stowarzyszeniefidesetratio.pl/fer/2022-1Szczygiel.pdf

33 Smyczyńska J. (2023). Opieka medyczna nad dziećmi i młodzieżą z dysforią płciową i niezgodnością płciową w świetle aktualnych rekomendacji – jak realizować zasadę primum non nocere? *Kwartalnik Naukowy Fides et Ratio*, Nr 3(55), pp.1-21. https://www.stowarzyszeniefidesetratio.pl/fer/2023-3Smy.pdf

34 Dora, M., Grabski, B., Dobroczyński, B. (2021). Gender dysphoria, gender incongruence and gender non-conformity in adolescence – Changes and challenges in diagnosis. Psychiatria Polska, 55(1), pp. 23–37. https://doi.org/10.12740/PP/OnlineFirst/113009

35 Littman L. (2021). Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners. Vol.:(0123456789)1 *3Archives of Sexual Behavior,* 50, s. 3353–3369;

36 Butler C., Hutchinson A. (2020). Debate: The pressing need for research and services for gender desisters/ detransitioners. *Child Adolesc Ment Health* Feb, 25(1), pp.45-47. doi: 10.1111/camh.12361.

37 Łukasz Sakowski (5-04-2023). Moja historia cofnięcia zmiany płci. Tranzycja i detranzycja. *To tylko teoria.* https://www.totylkoteoria.pl/tranzycja-detranzycja-zmiana-plci/

38 Daniela Valdes and Kinnon MacKinnon (18-01-2023). Take Detransitioners Seriously. *The Atlantic.* https://www.theatlantic.com/ideas/archive/2023/01/detransition-transgender-nonbinary-gender-affirming-care/672745/

39 Marianowicz-Szczygieł (21-02-2023). Detranzycja. Oni żałują „zmiany płci". *Afirmacja.info* https://afirmacja.info/2023/02/21/detranzycja-oni-zaluja-zmiany-plci/

40 Heyer, W. (2018). *Trans life survivors*. Walt Heyer.

41 Heyer, W. (2020). *Articles of Impeachment against Sex Change Surgery*. Walter Heyer.

42 Afirmacja tv. (27-09-2026). Ignorancja lekarzy i słodkie kłamstwa w sieci. Zobacz świadectwo Magdy zmanipulowanej do tranzycji [Doctors' ignorance and sweet lies on the Internet. See the testimony of Magda who was manipulated into transition - English subtitles]. https://www.youtube.com/watch?v=81Js9QtlX1s

43 Vandenbussche E. (2021). Detransition-related needs and support: A cross-sectional online survey. *Journal of Homosexuality*, online. ttps://www.tandfonline.com/doi/pdf/10.1080/00918369.2021.1919479?needAccess=true

44 de Vries A.L.C., Cohen-Kettenis P.T. (2012). Clinical Management of Gender Dysphoria in Children and Adolescents: The Dutch Approach, *Journal of Homosexuality*, 59 (3), pp. 301-320 http://dx.doi.org/10.1080/00918369.2012.653300 ; Dora M., Grabski B., Dobroczyński B. (2020). Dysforia płciowa i nonkonformizm płciowy w adolescencji - zmiany i wyzwania diagnostyczne, *Psychiatria Polska*, 162, pp.1-15, https://doi.org/10.12740/PP/OnlineFirst/113009

WPATH standards - versions 7 and 8[45], Endocrine Society standards[46]) have been criticized not only in the documents cited above but also in dedicated publications[47] [48] [49] as being based on evidence of low or very low quality according to the GRADE[50] evaluation system. Such therapies are referred to as experimental. Taken together health authorities including lawmakers, government agencies, and professional association statements in 11 countries[51] have been already taken steps toward mowing away from the affirmative approach or move to a more balanced and cautious stance (including aforementioned ones like Sweden, the UK, France, Finland, Norway, Australia, New Zealand, but also the USA[52], Hungary[53], and recently Denmark[54]). In Italy, such an approach is called for by the Italian Psychoanalytic Society[55]. In this study, we advocate for a holistic, integrated approach that utilizes, among other things, the findings of developmental psychology, personality psychology, clinical and family psychology, and non-invasive, safer, and scientifically well-grounded methods.

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45 WPATH - 8. Colman i in. (2022) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, *International Journal of Transgender Health*, 23(sup1), pp.S1-S259, DOI:10.1080/26895269.2022.2100644 ; WPATH - 7. WPATH (2012). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. https://www.wpath.org

46 Hembree W.C., Cohen-Kettenis P.T., Gooren L., Hannema S.E., Meyer W.J., Murad M.H., Rosenthal S.M., Safer J.D.,Tangpricha V., T'Sjoen G.G. (November 2017). Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline. *J Clin Endocrinol Metab*, 102(11), pp.3869–3903 doi: 10.1210/jc.2017-01658

47 Block J. (23-02-2023). Gender dysphoria in young people is rising—and so is professional disagreement. BMJ 2023(380), p382; doi: https://doi.org/10.1136/bmj.p382

48 Abbruzzese E., Levine S. B., Mason J. W. (2023). The myth of "reliable research" in pediatric gender medicine: a critical evaluation of the Dutch Studies—and research that has followed. *Journal of Sex & Marital py*. DOI:10.1080/0092623X.2022.2150346

49 Biggs M.(2022). The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence. *Journal of Sex & Marital Therapy*. DOI:10.1080/0092623X.2022.2121238

50 https://bestpractice.bmj.com/info/toolkit/learn-ebm/what-is-grade/

51 The word "countries" refers to either legal changes, responses from health care agencies, or documents from professional, opinion-forming associations.

52 Human Rights Campaign (6-01-2023). Map: Attacks on Gender Affirming Care by State. https://www.hrc.org/resources/attacks-on-gender-affirming-care-by-state-map

53 Rzeczpospolita (20-05-2020). Węgry zakazują legalnej zmiany płci. https://www.rp.pl/spoleczenstwo/art711691-wegry-zakazuja-legalnej-zmiany-plci

54 Hansen M.V. , Giraldi A., Main K.M., Tingsgård J.V., Haahr M.E. (3-11-2023). Ugeskrift for Læger. Sundhedsfaglige tilbud til børn og unge med kønsubehag. (Opieka zdrowotna dla dzieci i młodzieży z dysforią płciową). https://ugeskriftet.dk/videnskab/sundhedsfaglige-tilbud-til-born-og-unge-med-konsubehag

55 Societa Psicoanalitica Italiana (12.01.2023). Disforia di Genere. Il comunicato dell'Esecutivo della SPI. https://www.spiweb.it/la-cura/disforia-di-genere-il-comunicato-del-presidente-s-thanopulos-12-01-23/; See also: *Feminist Post. (17 Jan. 2023). Italian psychoanalysts: Stop puberty blockers. Italian Psychoanalyst Society's letter to Gorgia Meloni. https://feministpost.it/en/primo-piano/gli-psicanalisti-italiani-stop-ai-puberty-blockers/*. https://www.dailywire.com/news/italian-psychological-association-expressed-great-concern-over-puberty-blocking-drugs?inf_contact_key=5f4f5a2dc69a3b2e9ba1748470b5556bb7af0999dac2af6212784c39e05d2aef

III. BASIC INFORMATION, TERMINOLOGY, AND DEVELOPMENTAL FRAMEWORKS

1. Gender identity disorders combined with transsexual tendencies (most often diagnosed as transsexualism in ICD-10 or gender dysphoria in DSM-5, in ICD-11 referred to as gender incongruence) are disorders with complex causes, that are still an object of scientific exploration. However, most biopsychosocial data suggest a dominant environmental component in the genesis of this phenomenon, which will have a different configuration in each and every case. In other words, contrary to popular belief, these disorders are mostly acquired, not congenital [56] [57] [58] [59] [60] [61] [62].

2. Efforts to replace the current term commonly used in the context of gender identification disorders, namely transsexualism, with the ICD-11 term 'gender incongruence' (or gender incongruity), moreover in a newly created category "Conditions related to sexual health" and understood as a discrepancy between the 'experienced gender' and the 'assigned sex'[63] - is, as we think, a misguided approach. It simplifies the complicated matter of gender identity dysfunction to individuals' subjective declarations, essentially preventing diagnosis of possible predisposing or underlying causal disorders and depriving individuals of public

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56 American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) (2022). Gender dysphoria. Washington, DC: American Psychiatric Association. pp. 511-520. See especially pp. 511, 517. https://www.psychiatry.org/Psychiatrists/Practice/DSM/Educational-Resources/Assessment-Measures

57 Lee P.A., Nordenström A., Houk C.P., Ahmed S.F., Auchus R., Baratz A., Dalke K.B., Liao L., Lin-Su K., Looijenga L.H.J., Mazur T., Meyer-Bahlburg H.F.L., Mouriquand P., Quigley C.A., Sandberg D.E., Vilain E., Witchel S., the Global DSD Update Consortium (2016). Consensus statement: global disorders of sex development update since 2006: perceptions, approach and care. *Hormone Research in Pediatrics*, 85, pp.158–180. See p. 168. https://doi.org/10.1159/000442975

58 Becerra-Culqui T.A., Liu Y., Nash R., Cromwell, L., Flanders, W.D., Getahun, D., Giammattei, S.V., Hunkeler, E.M., Lash, T.L., Millman, A., Quinn, V.P., Robinson, B., Roblin, D., Sandberg, D.E., Silverberg, M.J., Tangpricha V., Goodman, M. (2018). Mental health of transgender and gender nonconforming youth compared with their peers. *Pediatrics*, 141(5), e20173845. https://doi.org/10.1542/peds.2017-3845 See especially Tables 2 and 3.

59 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 and Marital Therapy*, 43(7), pp. 678–688. https://doi.org/10.1080/0092623X.2016.1232325

60 Kozlowska K. McClure G., Chudleigh C., Maguire A., Gessler D., Scher S., Ambler G. (2021). Australian children and adolescents with gender dysphoria: clinical presentations and challenges experienced by a multidisciplinary team and gender service. *Human Systems: Therapy, Culture and Attachments*, 1(1), pp.70-95. https://doi.org/10.1177/26344041211010777

61 Thrower E., Bretherton I., Pang K.C., Zajac J.D., Cheung A.S. (2019). Prevalence of autism spectrum disorder and attention-deficit hyperactivity disorder amongst individuals with gender dysphoria: a systematic review. *Journal of Autism and Developmental Disorders*, 50, pp. 695-706. https://doi.org/10.1007/s10803-019-04298-1

62 A review of research on the genesis in: Marianowicz-Szczygieł A. (2021). Zaburzenia tożsamości płciowej u dzieci i młodzieży – ujęcie psychologiczne. Geneza, czynniki ryzyka, rokowania, profilaktyka, (in:) B. Kmieciak, P. Sobczyk (eds), *Między chromosomem, a paragrafem. Transseksualizm w ujęciu prawno- społeczno-medycznym*, pp. 93-142, Warszawa: Wydawnictwo Instytutu Wymiaru Sprawiedliwości

63 ICD-11, code HA61: „gender incongruence of childhood" - https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f344733949

health care rights. It also implies at the same time the elimination of biological sex, replacing it with terms like 'assigned sex' or 'experienced gender'[64]. It is equally flawed to use a subjective distress criterion[65] in the definition of 'gender dysphoria' as is the case in DSM-5, DSM-5-TR, and ICD-11. Therefore, we prefer the term 'gender identity disorders,' abbreviated 'G.I.D.' **Our proposal concerns changes in terminology as well as diagnostics and therapy, not the denial of the phenomenon itself**. Instead of absolute subjective beliefs of children and adolescents, we suggest a cause-effect approach, anchoring therapy in detailed somatic, psychiatric, sexological, and psychological diagnostics. Current practices lead to traumatic outcomes for individuals, evidenced by the increasing number of testimonies and detransition procedures. These point to fundamental errors in diagnostic procedures and an overly casual branding with the label of 'transexualism' by part of the healthcare community.

3. Gender identity disorders in children and adolescents most often resolve spontaneously in 73% - 98% of cases[66] [67]and may be a temporary exploration of identity. This suggests that doubts about gender identity should be considered in the context of general developmental norms, related to the spheres of social relations, changed hormonal balance, numerous mood and self-esteem fluctuations, the search for one's identity, the development of thinking processes and intelligence, the gradual shaping of morality, and critical thinking. The human brain continues to develop until the ages of 23 - 25, and some functions until even later.

4. We can observe a new social phenomenon, scarcely researched and not included in current classifications and diagnostic-therapeutic standards (and even denied by some specialists), namely a rapid increase in transsexual declarations[68], especially among teenage girls with no previous history of such tendencies, referred to as ROGD (rapid onset gender dysphoria). Current analyses indicate that the causes of this phenomenon may be related to the influences

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64 Instytut „Ona i On" (7-09-2023).ICD-11 – c.d – zaangażuj się i pomóż nam zastopować groźne zmiany! http://onaion.org.pl/2023/09/07/20063/

65 Marianowicz-Szczygieł A. (12-02-2023). Koń trojański kilku współczesnych ideologii. Ujawniamy kulisy manipulacji w diagnostyce. *Afirmacja. info*. https://afirmacja.info/2023/02/12/ujawniamy-kulisy-manipulacji-w-diagnostyce/

66 Steensma A. and all (2011) report the persistence of gender dysphoria at 2% - 27%, B. Wallien (2008) - 27%. Mentioned publications are: 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), pp. 499–516. https://doi.org/10.1177/1359104510378303; Wallien M. S. C. (2008). Gender Dysphoria in Children: Causes and Consequences [Vrije Universiteit]. https://research.vu.nl/en/publications/gender-dysphoria-in-children-causes-and-consequences; Drummond K.D., Bradley S.J., Peterson-Badali M., Vanderlaan D.P. (2017). Behavior problems and psychiatric diagnoses in girls with gender identity disorder: a follow-up study, *Journal of Sex and Marital Therapy*, 44(2), pp.1-16. DOI: 10.1080/0092623X.2017.1340382

67 Cantort J. (11-01-2016). Do trans- kids stay trans- when they grow up? *Sexology Today*. http://www.sexology-today.org/2016/01/do-trans-kids-stay-trans-when-they-grow_99.html

68 Marianowicz-Szczygiel A. (2022). Rise of gender identity disorders among children and adolescents- data from 10 countries. *Kwartalnik Naukowy Fides Et Ratio*, 49(1), pp. 122-141. https://doi.org/10.34766/fetr.v49i1.1060 https://fidesetratio.com.pl/ojs/index.php/FetR/article/view/1060/724

of culture and media.[69] [70] [71] [72], and the activities of pro-transsexual activists[73]. The phenomenon is sometimes referred to as 'epidemic-like,[74] 'iatrogenic' even a 'peer contagion' or 'social epidemic' [75]. This mandates additional caution.

5. As shown by the aforementioned research reviews, the so-called medical transition in the gender-affirming model (commonly referred to as a 'sex change'), which includes the use of puberty blockers, cross-sex hormones, and surgical operations, is, especially in children and adolescents, highly unethical and risky for multiple reasons. It has not passed tests of systematic research reviews, rigorous meta-analyses and research replicability. Hormonal drugs are being used contrary to their previously established purpose (e.g., chemical castration, treatment of precocious puberty). Medical transition leads to infertility, creates a risk of disorders, especially of the skeletal system, thromboembolic syndromes, liver diseases, cancer, and others, leads to sexual dysfunctions (reduced libido, or even the inability to orgasm, painful vaginal atrophy associated with dryness or cracking of its walls, clitoris enlarged irreversibly under the influence of testosterone), and also causes irreversible voice thickening, androgenic alopecia, symptoms of chemical menopause in teenagers, stunted growth (and the risks of complications associated with surgery or mental problems should be added here). Its impact, especially on brain development in children and adolescents, is unknown; there are no estimated long-term effects. Sex hormones affect the sexual differentiation of the brain and its attainment of full maturity, and the 'plasticity' of brain neurons continues at least until the end of sexual maturation[76]. It can be observed that the use of sex hormones for "sex change" before the end of brain development carries a significant risk of perpetuating the sexual differentiation of the brain in a direction inconsistent with biological sex; it is not, therefore, a neutral "affirmation"

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69 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

70 Indremo M., Jodensvi A., Arinell H., Isaksso J., Papadopoulos F. (2022). Association of media coverage on transgender health with referrals to child and adolescent gender identity clinics in Sweden. *JAMA Network Open*. 5. e2146531. 10.1001/jamanetworkopen.2021.46531.

71 Littman L. (16-04-2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria, *Plos One* 14(3):e0202330, https://doi.org/10.1371/journal.pone.0202330.

72 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

73 An Open Letter to the American Academy of Pediatrics 18 July 2022. https://genspect.org/an-open-letter-to-the-american-academy-of-pediatrics/

74 French National Academy of Medicine (25-02-2022). Medicine and gender transidentity in children and adolescents. https://www.academie-medecine.fr/la-medecine-face-a-la-transidentite-de-genre-chez-les-enfants-et-les-adolescents/?lang=en

75 The last three terms were used in the work: Shier A.. Nieodwracalna krzywda, *op.cit.*

76 Trova S., Bovetti S., Bonzano S., De Marchis S., Peretto P. (2021). Sex Steroids and the Shaping of the Peripubertal Brain: The Sexual-Dimorphic Set-Up of Adult Neurogenesis. *Int J Mol Sci* Jul 26;22(15):7984. doi: 10.3390/ijms2215798

but an interference in the development of the still-forming brain. In adolescence, different gender patterns of behaviour associated with brain development have been observed in girls and boys (different rates of brain growth, myelination, and stimulation of different areas in the brain by sex hormones translate, for example, into a different mode of achieving emotional maturity, impulse control, or risk susceptibility)[77] [78] [79]. These processes are not fully understood. Thus, medical transition, objectively multi-stage and as complicated as it is unpredictable, is currently considered an experimental intervention worldwide[80]. Society should strive to prevent children from making such risky, impulsive, far-reaching, and irreversible decisions. Currently, increasing "professional positions of a cautious, mixed, or holistic nature can be observed within Sweden, Norway, Finland, Denmark, United Kingdom, United States, France, Australia, and New Zealand. In over 20 US states, legislation has been enacted that prohibits 'gender neutralization' in children under 18[81]. Stepping back in the area of gender-affirming policies for minors has been written about by leading media around the world: Forbes[82], Reuters[83], Euronews[84], The Atlantic[85], CBN[86], or The Guardian[87]."[88]

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77 Luna B. et all. (May 2001). Maturation of Widely Distributed Brain Function Subserves Cognitive Development, *NeuroImage* 13 (5), pp. 786–93, https://doi.org/10.1006/nimg.2000.0743.

78 Giedd J.N. (19 May 2015). The amazing teen brain. *Scientific American* 312 (6), pp.32–37, https://doi.org/10.1038/scientificamerican0615-32. https://www.researchgate.net/publication/277935210_The_Amazing_Teen_Brain

79 Arain M., Haque M., Johal L., Mathur P., Nel W., Rais A., Sandhu R., Sharma S.(2013). Maturation of the adolescent brain. *Neuropsychiatr Dis Treat* 9:449-61. doi: 10.2147/NDT.S39776. Epub 2013 Apr 3. PMID: 23579318; PMCID: PMC3621648

80 Although, some gender-affirming standards like WPATH state otherwise.

81 Human Rights Campaign (15-09-2023). Map: Attacks on gender affirming care by state. https://www.hrc.org/resources/attacks-on-gender-affirming-care-by-state-map

82 Bushard B. (29-03-2023). Kentucky Becomes 12th state to ban gender affirming care after GOP lawmakers override governor's Veto. *Forbes*. https://www.forbes.com/sites/brianbushard/2023/03/29/kentucky-becomes-12th-state-to-ban-gender-affirming-care-after-gop-lawmakers-override-governors-veto/

83 Respaut R., Terhune Ch., Conlin M. (22-12-2022). Why detransitioners are crucial to the science of gender care. *Reuters*.https://www.reuters.com/investigates/special-report/usa-transyouth-outcomes/

84 Min R. (17-02-2023). As Spain advances trans rights, Sweden backtracks on gender-affirming treatments for teens. *Euronews*. https://www.euronews.com/next/2023/02/16/as-spain-advances-trans-rights-sweden-backtracks-on-gender-affirming-treatments-for-teens

85 Valdes D., MacKinnon K. (18-01-2023). Take detransitioners seriously. *The Atlantic*. https://www.theatlantic.com/ideas/archive/2023/01/detransition-transgender-nonbinary-gender-affirming-care/672745/

86 Morris A.. (21-03-2022). A tidal wave of transgender regret for hundreds of people: 'They don't feel better for it' *CBN*. https://www2.cbn.com/cbnnews/world/2019/october/a-tidal-wave-of-transgender-regret-for-hundreds-of-people-they-dont-feel-better-for-it?fbclid=IwAR0XJLnH44P6tSDZ0nvUuFvAfaPJAXl0U1YmR4Be6E6mmwecMPL4-F3w2pY

87 Batty D. (30-07-2004). *Sex changes are not effective, say researchers. The Guardian*. https://www.theguardian.com/society/2004/jul/30/health.mentalhealth

88 Marianowicz-Szczygieł A. Review of 22 standards and models of assistance for children and adolescents with gender identity disorders - recommendations for the Polish model. *in press*

6. So-called social transition, especially in public (in contrast to non-clinical) situations, carried out for individuals who are still developing (changing names, pronouns, clothing, access to spaces reserved for the opposite sex) can reinforce gender identity disorders in a given child and affect those around them (other children, teachers, parents, social environment). Providing such children and young people with care based on comprehensive guidance is required, which is the purpose of this document (see also point IV.5.)[89]

7. There is a broad spectrum of mental disorders in children and adolescents that intersect with transsexual tendencies (separation anxiety, autism spectrum disorders including Asperger's syndrome, depression, suicidal tendencies, disorders in self-image, body perception, and self-worth), as well as specific family environment traits[90] [91] [92] [93]. Symptoms of gender identity disorders may thus be only symptoms caused by other types of factors. Therefore, a young person's problems related to gender identity should not be treated in isolation or solely from a social perspective.

8. For the same reason, the diagnosis of gender identity disorders should be made by a broad, interdisciplinary team of specialists (see detailed recommendations below). A single certificate from one specialist or just a few diagnostic meetings should never be a sufficient basis for starting any transition, especially medical. Any professional interventions should also take place within the framework of the aforementioned team of specialists.

9. While all reports of depression or suicidal tendencies should be taken seriously and with appropriate attention, in the case of children and adolescents, especially those under the influence of activists, they may be just a means of emotional blackmail to obtain a prescription for medical interventions or a result of the Werther effect. There has also been described outright indoctrination and coaching of youth to deceitfully persuade a parent/legal guardian to consent to transition[94].

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89 Olson K., Durwood L., Horton R., Gallagher N., Devor A. (2022). Gender identity 5 years after social transition. *Pediatrics*, special article. https://pubmed.ncbi.nlm.nih.gov/35505568/

90 Kozlowska K., McClure G., Chudleigh C., Maguire A., Gessler D., Scher S., Ambler G. (2021). Australian children and adolescents with gender dysphoria: clinical presentations and challenges experienced by a multidisciplinary team and gender service. *Human Systems: Therapy, Culture and Attachments*, 1(1), pp.70-95. https://journals.sagepub.com/doi/pdf/10.1177/26344041211010777

91 Hisle-Gorman E., Schvey N.A., Adirim T.A., Rayne A.K., Susi A., Roberts T.A., Klein D.A. (2021). Mental healthcare utilization of transgender youth before and after affirming treatment. *Journal of Sexual Medicine*, 18, pp.1444−1454. https://pubmed.ncbi.nlm.nih.gov/34247956/

92 Becerra-Culqui T.A., Liu Y., Nash R., Cromwell L., Flanders W.D., Getahun D., Giammattei S.V., Hunkeler E.M., Lash T.L., Millman A., Quinn V.P., Robinson B., Roblin D., Sandberg D.E., Silverberg M.J., Tangpricha V., Goodman M. (2018). Mental health of transgender and gender nonconforming youth compared with their peers. *Pediatrics*, 141(5), e20173845. https://doi.org/10.1542/peds.2017-3845

93 See: Glintborg, D., Mřller, J.J.K., Rubin, K.H., Lidegaard, O., T'Sjoen, G., Larsen, M.L.J.O., Hilden, M., Andersen, M.S. (2023). Gender-affirming treatment and mental health diagnoses in Danish transgender persons: A nationwide register-based cohort study. *European Journal of Endocrinology*, 189, pp. 336-345. https://doi.org/10.1093/ejendo/lvad119

94 Shrier A. (2023). *Nieodwracalna krzywda*. Kraków: Dystrybucja AA.

There is no scientific data indicating automatic suicidality in cases of gender identity disorders, or even suggesting that transition would supposedly protect against suicide[95], especially since adolescence itself is generally characterized by an increased risk of suicidal tendencies.

10. For medical, psychological, and social reasons, we are also opposed to the use by children and adolescents of the so-called binders (compressing and camouflaging the breasts) [96] or wrapping and hiding male genitalia.

IV. SOCIAL POLICY AND GENERAL FRAMEWORKS FOR PROFESSIONAL ASSISTANCE

1. The fundamental principle of assistance should be: first, do no harm - benefits should outweigh the risk. Diagnostics in the case of gender identity disorders are complex, multi-stage, and multidimensional. Emphasis should be placed on examining all threads that could influence gender perception issues.
2. Every patient and their guardians have the right to full, comprehensive, and reliable information regarding the etiology of disorders, including gender identity disorders, and information about available treatment options, including the effects of puberty blockers and sex hormones, the consequences of surgical interventions, and the risks of irreversible changes (the risks of infertility, removal of healthy organs, use of pharmacological interventions, primarily thromboembolic incidents, increased cancer risk).
3. In planning assistance, utmost caution should be maintained, partly due to the changes during development, but passivity should not be maintained (passivity is not neutral). A conscious consent for transition in the case of children and adolescents is a fiction.
4. Every patient should have the right to psychotherapy as a primary form of

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95 "The suicide risk was significantly higher than in the general population, but at the same level as the suicide risk of common mental disorders such as depression, bipolar disorder and autism. Because these mental disorders are so common among people with gender incongruence, it is not possible to determine whether the increased risk of suicide is due to gender incongruence per se or is a consequence of the mental disorder. There is also no research that provides evidence that the risk of suicide is reduced by gender-affirming treatment or that the risk of suicide increases if gender-affirming treatment is not provided." Norwegian Healthcare Investigation Board - UKOM (9-03-2023). Pasientsikkerhet for barn og unge med kjønnsinkongruens. https://ukom.no/rapporter/pasientsikkerhet-for-barn-og-unge-med-kjonnsinkongruens/sammendrag chapter7, p.26

96 The risks of negative medical effects of using binders include: pain (chest, arms, back), breathing problems (such as shortness of breath), skin problems (such as itching, wounds, abrasions), neurological problems (e.g. headache, dizziness), problems with the skeletal system and muscles (e.g. numbness, changes in the ribs, posture defects), overheating and even gastric problems. More than 97% of subjects reported at least one of 28 negative side effects. Source: Gardner I., Weinand J., Corbet A., Acevedo K. (2016). Health impact of chest binding among transgender adults: a community-engaged, cross-sectional study. *Culture, Health & Sexuality*, 19, pp.1-12. 10.1080/13691058.2016.1191675. DOI: 10.1080/13691058.2016.1191675

treatment, that does not leave permanent and irreversible somatic effects. When appropriate, psychotherapy should involve the entire family system.

5. The extraordinary psychodynamics of adolescence, dominantly acquired genesis, and the mostly spontaneous resolution of transsexual feelings are sufficient arguments not to support the so-called social transition in social life and choices made by some teenagers, e.g., chosen pronouns, name changes, access to single-sex spaces reserved for the opposite sex, etc. However, such individuals should always be surrounded with kind support and provided with psychotherapeutic care. Changing names or pronouns introduced by educational institutions at all levels of education, including in documents containing personal data or gender markers, is not only an action against the welfare of the child and young person but also a violation of parents' rights and the objective legal, scientific, and social order. Also, for individuals over 18 remaining in the education system, especially if no legal change has been made in the registry, such practices should be considered reprehensible.

6. Rightly promoting respect for others, based on Christian values close to us, does not require creating catalogues of groups sensitive to discrimination, as in fact it leads to their distinction against other groups, typically not listed. Respect and wise "love of neighbour" is a universal, sufficient, and well-known concept anchored in Judeo-Christian tradition[97] - empathetic and merciful, but also courageous love capable of setting boundaries for the good of the individual when necessary. So we oppose all forms of pressure against children and adolescents, especially in the school system, which may result in disturbing their yet unformed identity, such as: special rainbow counselling, clubs, events like "rainbow Friday," meetings with LGBT+ individuals, e.g., in the form of living libraries[98], and even more so, easy access to sex hormones (including their reimbursement for transition purposes). Even anti-discrimination, equality and diversity-related actions and standards are unfortunately often in the form of activism.

7. Knowledge from not only developmental psychology indicates that so-called gender-neutral upbringing prevents the development of a gender identity consistent with one's biological sex. Therefore, we strongly oppose such practices, especially in the case of preschool children.

8. The increasing cases of detransition point to previous procedural and diagnostic errors. Individuals undergoing detransition should be guaranteed care from endocrinologists and psychotherapists, as well as legal support in returning to their biological sex (although some consequences of earlier medical procedures may be irreversible). There is „life after detransition," and there is hope for such individuals.

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97 Haynes L. (Sept. 16, 2019). Are religious Californians really harming the mental health of people who identify as LGBTQ? https://www.thepublicdiscourse.com/2019/09/56790/

98 See: Kosciw J. G., Greytak E. A., Zongrone A. D., Clark C. M., Truong N. L. (2018). The 2017 National School Climate Survey: The experiences of lesbian, gay, bisexual, transgender, and queer youth in our nation's schools. New York: GLSEN., p. 163, Appendix 2., https://files.eric.ed.gov/fulltext/ED590243.pdf

9. We oppose all attempts to isolate parents from their children with gender identity disorders or to limit parental authority on this basis, including those demonstrated in WPATH standards (SOC 7 and SOC 8)[99] - standards that ignore scientific achievements, unreliable, extremely one-sided, and which do not apply the requirements of cause-and-effect thinking. It is essential to carefully maintain good relations between the child and parents and vice versa. The so-called "glitter" or "transgender family" (a group of people unknown to the child, affirming their new gender identity, and claiming to be the closest people to them now) cannot and will not replace natural family bonds.

10. The legal system should include, at least for the minors, and especially in relation to individuals with an unformed personality[100]: a prohibition against social, hormonal, surgical, and legal transition, especially irreversible steps, a prohibition against causing infertility or permanent body disfigurements [101], particularly without the consent of parents/legal guardians. We also recommend a ban on harmful educational activities related to gender and sexuality for individuals in the education system, including without the consent of parents/legal guardians (see points 11 and 14). We also call for the legal requirement to inform the immediate family about any social, medical, or legal transition, also in the case of adults, and the necessity to conduct a family interview with their participation, including the mandatory collection of information from parents/legal guardians about medical, social, psychological, and moral doubts (transition is not a mere medical procedure or official name change, but a change of identity that also affects the family).

11. We advocate for the mandatory inclusion of a psychological opinion in court proceedings in this area. However, in our opinion, issuing singular certificates referring for or prescribing so-called transition procedures should be prohibited, especially by specialists employed or cooperating with clinics performing medical transitions. The diagnostic and therapeutic process itself should be legally regulated, if possible, e.g., according to the guidelines proposed by us below.

12. We also see social, individual, and especially medical benefits in always recording

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99 The WPATH standards postulate: " Involvement of parent(s)/guardian(s) in the assessment process, unless their involvement is determined to be harmful to the adolescent or not feasible " (WPATH SOC-8, p. 256).

100 On the basis of general knowledge in the field of neurobiology and developmental psychology (brain and personality development - see notes 60-62) and detailed knowledge covering issues related to the development of gender identity disorders, a more justified age when it comes to the legal limit of the minimum admissibility of transition is the limit of 26 years. This type of law is proposed by some US states (Oklahoma, Texas, South Carolina) - see Human Rights Campaign (6/01/2023). Map: Attacks on Gender Affirming Care by State. https://www.hrc.org/resources/attacks-on-gender-affirming-care-by-state-map. SEGM, i.e. the Society for Evidence-Based Gender Medicine, a scientific organization bringing together over 100 scientists and clinicians from several countries, also opts for a late age limit of 25 years. This is also consistent with the suggestions of the Norwegian UKOM and the British Cass Review (also the 25-year limit); sources: SEGM (28/05/2021). "Gender-affirming" Hormones and Surgeries for Gender-Dysphoric US Youth. https://segm.org/ease_of_obtaining_hormones_surgeries_GD_US; UKOM (9/03/2023). Pasientsikkerhet for barn og unge med kjønnsinkongruens (Safety of patients with gender nonconformity). https://ukom.no/rapporter/pasientsikkerhet-for-barn-og-unge-med-kjonnsinkongruens/sammendrag; Cass, H. (February 2022). The Cass Review. Independent review of gender identity services for children and young people: Interim report. https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim-Report-Final-Web-Accessible.pdf

101 We are talking about practices that are not justified by medical reasons and are undertaken for cultural, social or psychological reasons.

biological sex in professional documentation, especially medical.

13. We also oppose gender "newspeak" and language inclusivity, abandoning terms in public spaces like "woman and man," "mom and dad," "ladies and gentlemen." We oppose concepts that have no biological justification, such as "menstruating persons," "pregnant person," "sex assigned at birth," "gender expressions," "gender diversity," etc.

14. We also call for monitoring educational and legal changes related to gender and sexuality that affect children and adolescents, including those from the EU and UN agendas, and counteracting adverse changes (e.g., denouncing the Istanbul Convention in Poland or depriving it of its gender "edge," revising or not implementing the ICD-11 classification in Poland, which sanctions gender as a perceived sex instead of biological sex, and treats gender identity disorders as a manifestation of "sexual health")[102].

15. In our opinion, the patients' and their families' right to self-determination in choosing and accessing psychotherapy should also be under special legal protection. We oppose unjustified and misleading public bans on psychotherapy for gender and sexual disorders that strike at fundamental civil liberties.

16. We also oppose any attempts to limit freedom of speech, religious freedom, business, or academic freedom related to LGBT+ topics. We demand respect for the Christian worldview, the right to a fair and substantive scientific debate, and the separation of the individual sphere from the social one, where a long-term perspective is required with a priority on demographics, the common good, and the well-being of the child and their family.

17. We advocate for a comprehensive preventive approach at the national level. It would be advisable to include parents, children, and adolescents in an educational and preventive campaign combined with the possibility of early detection of gender identity issues.

18. To make this possible, we postulate the proper inclusion of these issues in the under-graduate and post-graduate training of doctors and other medical staff, psychologists, and educators, in line with current knowledge.

19. The areas where the state can influence through its policies in the case of gender identity disorders and their prevention are, in order (from broadest to narrowest): A. general support for the family in its basic functions, B. education, information and legal protection of families, C. targeted detailed prevention, D. screening research for early diagnosis, E. regulation of comprehensive and holistic diagnosis, F. organizing systematic psychotherapy in specialized centers, G. directional support.

20. We call for updated, systematic, and rigorous reviews of scientific literature, as well as support for long-term scientific studies comparing the effects of so-

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102 „Ona i On" Institute (7-09-2023). ICD-11 – c.d. – Zaangażuj się i pomóż nam zastopować groźne zmiany!. http://onaion.org.pl/2023/09/07/20063/

called watchful waiting and psychotherapy, as well as the functioning of children who have been helped by psychotherapy, those whose problems persist despite psychotherapy, and detransitioners.

21. We appeal to the international community and the authorities of the Republic of Poland to enact and apply laws that protect the proper development of children and adolescents and to create a system of qualified assistance for children with gender identity disorders, as well as training staff in this area[103].

V. DETAILED RECOMMENDATIONS FOR DEALING WITH CHILDREN AND ADOLESCENTS WITH GENDER IDENTITY DISORDERS OR SUSPICIONS THEREOF, AND BEST PRACTICES IN DIAGNOSIS AND THERAPY

1. We propose training staff and organizing a network of specialized facilities[104] which patients with gender identity disorders would be referred to.

2. We recommend that a patient with gender identity disorders be managed not by a singular specialist or a group of specialists, but by an **interdisciplinary team**, sharing information and experience (optimally composed of a psychologist, psychiatrist, paediatrician/family doctor, endocrinologist, gynaecologist/urologist, sexologist, educator, child and adolescent psychotherapist, family psychotherapist; with a leading role for the psychologist with medical support). Cooperation with the school environment is also advisable. In case of problems with access to this type of specialized and structured assistance, at least an exchange of information between the aforementioned specialists is recommended, or, in case of limitations, at least between the paediatrician/family doctor, psychologist, psychiatrist, endocrinologist, urologist/gynaecologist, with an emphasis on the coordinating role of the psychologist or paediatrician/family doctor. Relying on a single certificate, including without conducting an in-depth diagnosis of the child/young person, allowing transition on this basis should be penalised.

103 Currently, such assistance, due to the excessive medicalization of the approach and lack of regulation, usually takes place in cosmetic medical clinics; there are no appropriate standards and guidelines.

104 Foreign experience shows that it is useful to divide specialized facilities into local, regional and central levels. Such facilities may also include specialized and cooperative teams, and not necessarily stationary ones. It would be particularly advisable to train family doctors, pediatricians, school psychologists, employees of pedagogical and psychological counseling centers, and the staff of educational and care facilities, especially their directors.

PRELIMINARY DIAGNOSIS

In the case of suspected gender identity disorders (referred to as G.I.D.), after conducting an initial interview with parents/guardians and, depending on age, also with the child, a preliminary diagnosis should be made, i.e., a description of the symptoms and history of gender identity disorders, including gender nonconformity or behaviours atypical for the particular sex, should be checked and recorded from when these symptoms occur. Single sex-atypical behaviours, e.g., playing games typical for the opposite sex or single instances of dressing up, e.g., a small child in clothes of the opposite sex, do not qualify for the diagnosis of gender identity disorders. Persistent and strong symptoms such as (differentiation based on DSM-5, ICD-10 and ICD-11)[105]:

a) a strong desire to be of the opposite sex,

b) non-acceptance of one's body, including sexual organs and signs of maturation,

c) a strong desire to have primary and/or secondary characteristics of the opposite sex,

d) dressing in clothes of the opposite sex,

e) the desire to live and be accepted as the opposite sex,

f) preference for games, play, and activities typical for the opposite sex,

g) or even, in the case of adolescents, undergoing social transition (changing to names, gender pronouns, clothes, hairstyles of the opposite sex), functioning in roles typical for the opposite sex in public spaces, including on the Internet,

h) or taking steps towards so-called medical, hormonal, or surgical transition to simulate masculinisation/feminisation of appearance ('sex neutralisation'),

which last at least 6 months[106], qualify for the diagnosis of gender identity disorders. An essential part of the diagnosis is the differential diagnosis described further.

In the description of symptoms, special attention should be paid to two critical periods, i.e., early childhood (2 - 4 years) and puberty, including the child's reaction to signs of puberty. In the case of adolescents, especially girls, attention should be paid to differential diagnosis for ROGD syndrome, i.e., so-called rapid-onset gender dysphoria, which is characterized by a lack of history of gender identity disorders from early childhood. Any theatricality of behaviours, which often accompanies the ROGD syndrome, is worth noting.

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105 As already announced, we use an objective approach, based on facts and biological reality, i.e. we oppose the use of the criterion of distress, as in subjective discomfort – that is currently the case in the DSM or ICD classifications, i.e. diagnosing gender dysphoria, gender incongruity or gender incompatibility only if it causes discomfort for the patient or if it disturbs social functioning. That's why we use the broader term "gender identity disorder" (G.I.D.).

106 Time criteria based on the DSM index.

The next stage of the diagnostic procedure in the case of suspected gender identity disorders should be an assessment of somatic health status and, concurrently, differential diagnosis and comprehensive psychological diagnosis, assessment of the functioning of the family, and the social environment of the child/young person. Somatic diagnostics and differential diagnosis should not delay diagnostics and psychological help, but until its completion, the possibility of establishing a diagnosis other than gender identity disorders (G.I.D.) should be kept in mind. Because diagnostics in the direction of gender identity disorders are long, complicated, and absorbing (both in time and finances, even if these costs are covered by the state treasury) - great importance should be attached to the stage of preliminary diagnosis. In case of doubt, whether a given case meets the criteria for gender identity disorders and in the absence of other urgent circumstances, only the observation of the child should be considered, as well as postponing the decision to refer to detailed diagnostics (special caution should be shown in the case of ROGD syndrome, including lasting less than 6 months). However, during this period, meetings with a psychologist, psychotherapist (including within the family), counselling, and also providing educational advice to parents on how to support the child in the natural development would be advisable. This is also important due to the predominant developmental variability and natural "outgrowing" of children from such problems. The preliminary diagnosis is optimally made by a child or family psychologist.

PRELIMINARY ASSESSMENT OF SOMATIC HEALTH STATUS

The next step is a preliminary assessment of somatic health status (growth, weight, stage of somatic maturation considering the degree of maturation on the Tanner scale, presence of chronic diseases, basic laboratory tests). In the case of abnormalities in the genital organs, an additional gynaecological (for girls) or urological (for boys) consultation is needed if required. It is also essential to determine the patient's knowledge and attitude about maturation and its symptoms. If necessary, the specialist provides essential clarifications, especially in the case of an anxious attitude. The way of going through maturation has a diagnostic character and probably affects whether gender dysphoria subsides or not[107]. It's also necessary to assess health status for chronic diseases and somatic disorders, especially those related to sex (femininity, masculinity), alternatively conduct an examination of the genital organs for possible congenital developmental defects, perform basic laboratory tests, determine the concentration of glucose and electrolytes in the plasma, and conduct tests considering potential thyroid diseases or liver disorders. The medical interview in this regard should include the family history of diseases, including information about cancer and liver diseases. These activities are performed by the primary health care doctor.

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107 Steensma T.D., Boer F., Cohen-Kettenis P.T. (2011). Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study, *Clinical Child Psychology and Psychiatry*, 2011, vol. 16 (4), pp. 499-516. https://journals.sagepub.com/doi/abs/10.1177/1359104510378303

Differential Diagnosis

Next, a comprehensive differential diagnosis should be performed (somatic, psychiatric, and sexological), aimed at excluding other disorders that cause symptoms similar to gender identity disorders.

Somatic differential diagnosis (including endocrinological and genetic)

a) the necessity to exclude: DSD - disorders of sexual development and differentiation, cryptorchidism, hypogonadism, polycystic ovary syndrome (PCOS), congenital adrenal hyperplasia (including due to 21-hydroxylase deficiency), androgen insensitivity syndrome, growth disorders, maturation disorders related to: underweight/obesity, premature isolated breast enlargement, true and pseudo-precocious or delayed puberty, other hormonal disorders, post-traumatic disorders,

b) in the case of suspected Turner syndrome, Klinefelter syndrome, and other sex-related genetic syndromes, it is necessary to perform a karyotype examination, in girls with an assessment of Y chromosome markers (the scope of tests to be decided by the geneticist),

c) endocrine diagnostics:

   i) an interview considering the perinatal period (and drugs taken by the mother during pregnancy) and congenital defects, growth curve, the onset and course of sexual maturation, chronic diseases, and used medications (especially hormonal),

   ii) if indicated, an ultrasound of the lesser pelvis (assessment of the uterus and ovaries) in girls or an ultrasound of the testes in boys, in both genders an ultrasound of the abdominal cavity with an assessment of the adrenal glands,

   iii) panel of basic hormonal tests: determination of gonadotropin concentrations (LH and FSH), estradiol, testosterone, adrenal androgens (androstenedione, DHEA-S, 17-OH-progesterone) in both sexes (in menstruating girls, tests should be taken on the 2nd-5th day of the menstrual cycle); in children suspected of congenital adrenal hyperplasia not covered by the screening test, it is necessary to assess the level of 17-hydroxyprogesterone, testosterone, ACTH, cortisol, PRA (plasma renin activity), and aldosterone in the serum, and possibly an ACTH test.

   iv) If such a panel of tests does not show any abnormalities, we have no basis for determining hormonal influences of gender identity disorders. In the case of abnormalities - further diagnostics should be conducted

according to standards referring to specific situations, i.e., suspected disease entities (e.g., sex differentiation disorders, late-onset congenital adrenal hyperplasia, hormonally active tumours, etc.).

Psychiatric and Psychological Differential Diagnosis

It's necessary to diagnose and/or exclude:

a) psychoses (e.g., delusions of sex change[108]),

b) bipolar affective disorders,

c) dissociative disorders, gender-related phobias,

d) compulsive disorders, including castration obsessions,

e) PTSD related to sexual trauma,

f) intellectual disabilities,

g) borderline personality disorder (if present),

h) autism spectrum disorders - ASD (it's especially important to distinguish whether symptoms are a manifestation of ASD's focus on special interests),

i) nervous system disorders, including post-traumatic disorders resulting from, for example, encephalitis, concussion - if necessary, diagnostics using brain and CNS imaging tests are required,

j) other personality disorders and disorders due to organic brain dysfunctions (a neurological consultation would be advisable if needed),

k) BDD (body dysmorphic disorder, also known as dysmorphophobia),

l) BIID syndrome (body integrity identity disorder), where healthy individuals desire to become disabled,

m) or self-harm as the primary problem.

Differential Diagnosis Made by a Sexologist

(concerns older children, at least in puberty; questions may also be asked by a specialist other than a sexologist due to the sensitivity of the subject; it's necessary to diagnose what causes arousal, even in neutral situations)

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108 "Four possible variants of delusions of sex change in schizophrenia have been identified: (1) delusions of non-belonging to one's own sex; (2) delusions of not belonging to either sex; (3) delusions of simultaneous belonging to both sexes; and (4) delusions of belonging to the opposite sex [9–12]" p.1054 - See: Stusiński J., Lew-Starowicz M. (2018). Gender dysphoria symptoms in schizophrenia, *Psychiatr Pol* 52(6): pp.1053–1062 https://www.psychiatriapolska.pl/Gender-dysphoria-symptoms-in-schizophrenia,80013,0,2.html

a) exclusion of fetishism and fetishistic transvestism, as well as other disorders of sexual preference, where dressing in the clothes of the opposite sex or accessories related to the opposite sex (e.g., women's underwear, makeup) are the source of sexual arousal,

b) exclusion of autogynephilia or autoandrophilia (the thought of being the opposite sex causes sexual arousal),

c) exclusion of unaccepted homosexual tendencies as the primary motivation for the "neutralization" of biological sex (homosexual tendencies are statistically more frequently diagnosed in the group of people with gender identity disorders; here, attention should only be paid to the semblance of gender identity disorder symptoms against this background),

d) exclusion of other paraphilias.

Comprehensive Psychological Assessment

The comprehensive psychological assessment pertains to areas associated with the potential and known psychological origins of gender dysphoria (often overlooked)[109] and those areas that may be clinically relevant. The psychological diagnosis should aim to identify/assess the predisposing, precipitating, and perpetuating factors of gender identity disorders. The goal of psychological diagnostics is to understand the significance of the patient's symptoms, including in the family and social context, and to seek answers to the fundamental question: what mental problems are associated with gender identity disorders, and which are resolved symbolically thanks to them? The subjects of psychological diagnostics are the patient and their environment (parents/legal guardians, other key family members, and, if available, information from, for example, a school psychologist).

International practice indicates various modes of diagnostic meetings. Many institutions worldwide follow this order (besides psychological diagnostics using psychological tests, for which separate meetings are dedicated)[110]: at least one

109 Overview of research on genesis in the works: Marianowicz-Szczygieł A. (2021). Zaburzenia tożsamości płciowej u dzieci i młodzieży – ujęcie psychologiczne. Geneza, czynniki ryzyka, rokowania, profilaktyka, (in:) B. Kmieciak, P. Sobczyk (eds), Między chromosomem, a paragrafem. Transseksualizm w ujęciu prawno- społeczno-medycznym, 93-142, Warszawa: Wydawnictwo Instytutu Wymiaru Sprawiedliwości; (and the chapter about G. I. D. in:) Wieczorek B. (2018). Homoseksualizm. Przegląd światowych analiz i badań. Przyczyny, objawy, terapia, aspekty społeczne. Warszawa: Fronda. https://xlm.pl/autorzy/beata-wieczorek (pp. 263 – 274).

110 A detailed description of an exemplary diagnostic and therapeutic procedure is described in the work: A. Marianowicz-Szczygieł. Przegląd 20 standardów i modeli pomocy dzieciom i młodzieży z zaburzeniami tożsamości płciowej*, in press* following Zucker et all (2012). Diagnostics include 1. 30-90 min. telephone interview with parents, family interview (3 hours), individual interview with each parent (2-5 hours per parent), psychological tests with the child (4 hours), individual interview with the child (1 hour); Table 2 provides a complete list of diagnostic methods (psychological tests) used in the facility. Source: Zucker at all (2012). A developmental, biopsychosocial

joint preliminary meeting with children and parents, an interview with each parent separately, an interview with the child, observation of the child (pertains to pre-pubescent children), and a joint summarizing meeting with parents. Each meeting can last several hours (so not only the number but the quality of meetings counts). Specific areas are then further diagnostically deepened and appropriately explored during psychotherapy, including:

a) a detailed examination of the history of the patient's gender identity disorders and gender nonconformity (including noting significant/turning point events in the patient's opinion, as well as signals of the patient's gender rejection by the environment - e.g., changing the name to one of the opposite sex, verbalizing a desire to be of the opposite sex, dressing in the clothes of the opposite sex, noting the environment's reactions to gender identity disorders in the patient's perception);

b) the general state of mental health and its history,

c) assessment of mental resources (resilience) and social support,

d) assessment of intellectual development and educational achievements,

e) assessment of the level of emotional development, communication competencies,

f) self-image (especially significant discrepancies between real and ideal ego), self-acceptance, including acceptance of one's body and of developmental changes in the body,

g) noting tendencies for "concrete thinking" (thoughts experienced as physical actions) and a propensity for autosuggestion, the intensely realistic and emotional experiencing of one's thoughts,

h) difficulties with visual-motor coordination, aversion to team sports (especially relevant for boys),

i) interests atypical for a given sex and especially unaccepted in the given environment,

j) presence of current and past traumas, especially related to sex and sexuality,

k) potential violence, including sexual abuse,

l) perception of both masculinity and femininity and their attractiveness/unattractiveness, and any associations of safety, value, "strength" and "power" related to a given sex,

m) an interview regarding pornography addiction (history of using pornography, especially in conjunction with masturbation, traumas related to brutal pornography),

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model for the treatment of children with gender identity disorder. *Journal of Homosexuality* 59(3), pp. 369-397, DOI: 10.1080/00918369.2012.653309

n) traumatic contacts with the same/opposite sex, traumatic sexual initiation, sexual injuries (e.g., observing sexual scenes, which could lead to the rejection of one's sex/sexuality),

o) assessment of the impact of developmental identity exploration and related developmental testing in terms of gender,

p) assessment of the impact of so-called negative identity on femininity, masculinity perception and the desire for psychological separation from parents on this basis,

q) exclusion of alleged symptoms of gender identity disorders (G.I.D.) based on fears related to puberty and the possibility of unaccepted homosexual tendencies and "escape" from them in the desire to neutralize biological gender (exploration from the psychological side of themes already undertaken during differential diagnosis, this time in the context of the individual's overall functioning),

r) exclusion of ordinary uncertainty, curiosity, joking, oppositional behaviours, copying behaviours of the environment (example: the closest friend is also "trans"),

s) particular emphasis should be placed on the diagnosis of the autism spectrum,

t) depression/suicidality/self-harm,

u) anxiety disorders,

v) compulsiveness,

w) addictions,

x) eating disorders.

y) It is essential to have **an interview on social relationships and cultural messages** - contacts with the peer group, relational difficulties, social functioning in the school environment (rejection, isolation from peers), use of social media (to what extent?), the presence of influential people promoting for so-called sex change, messages about this in school and the immediate environment; it is necessary to examine whether the patient's sexuality, sex appearance was/is ridiculed, criticized by adults or peers, etc., and pay attention to exposure to transgender influencers and cultural messages (literature, comics - e.g., manga, films, and TV series, animated films e.g., anime, etc.) with transgender content. It is also crucial to analyse the sex stereotypes used by the patient (especially those negatively presenting a given sex).

z) An indispensable condition for psychological diagnosis, and then assistance, should be close cooperation with the family. The next stage is **the assessment of the family system** - in terms of family cohesion, homeostatic mechanisms, parenting styles, psychological roles understood as entrenched adaptive mechanisms, including in terms of gender roles, considering intergenerational transmission (unconscious induction of gender nonconformity), relational

problems between the child and parents, body image in individual family members, potential addictions, traumas, violence, including psychological violence[111]. It is also necessary to make an interview on the mental and physical health state of the parents (e.g., long hospital stays, mental illnesses, etc.), contacts with both parents (divorce, going abroad), and the intensity of contacts with the child. Attention should be paid to significant family experiences and possible developmental traumas in the child in the opinion of parents or family members. We also propose to examine methods of parental control and potential abuses in this area (especially towards a teenager). Diagnostic is the rejection of the child's sex (parents or extended family would prefer a boy instead of a girl or vice versa, they spoke about it directly or in a less conscious way encouraged to wear clothes, behaviours of the opposite sex). We recommend asking parents directly about their opinion on the possible causes of behaviours inconsistent with the child's sex. It should be noted how gender identity disorders were/are perceived in the family (shock, neutrality, acceptance, etc.), what the reactions looked like in practice, and check the influence of parents/family members on possibly maintaining symptoms, including noting any unusual situations. It is also necessary to help parents cope with current emotions related to the suspicion of G.I.D. in the child.

In cases where a diagnosis of Gender Identity Disorder (G.I.D.), also known as gender dysphoria, transsexualism, or gender incongruence/incompatibility, is confirmed, it is crucial **to provide information about the various available forms of assistance and therapy**, along with an evaluation of scientific evidence regarding their safety and effectiveness. There are three main approaches: the gender-affirming pathway, the mixed approach (somewhere in between the gender-affirming and the holistic approaches), and the pathway we can call holistic (see the end of part II). Notably, the affirming path within the so-called medical transition is not possible for every patient due to strict medical contraindications and life-threatening risks[112]. It is important to note the lack of reliable scientific evidence and professional consensus and to caution against the unjustified promotion in the public space of the gender-affirming

111 Disturbed gender dynamics and family structure from an intergenerational perspective are reported in studies, e.g.: Fajkowska M. (2001). Transseksualizm i rodzina: Przekaz pokoleniowy wzorów relacyjnych w rodzinach transseksualnych kobiet. Wydawnictwo Instytutu Psychologii PAN, Szkoła Wyższa Psychologii Społecznej.

112 Contraindications include, for example, liver diseases, blood clotting disorders, circulatory disorders, including cerebral circulation, coronary artery disease, thromboembolism (VTE), especially in people with a hypercoagulable state, deep vein thrombosis and pulmonary embolism, thrombophilia, hypertension, cancer, especially sensitive to estrogens, obesity, suicidal thoughts, self-harm, addictions such as smoking, sedentary lifestyle, pregnancy, apnea, polycythemia, hypercholesterolemia, and/or hypertriglyceridemia, hyperprolactinemia and gallstones - list based on: Hembree W.C., Cohen-Kettenis P.T., Gooren L., Hannema S.E., Meyer W.J., M. Murad H., Rosenthal S.M., Safer J.D., Tangpricha V., T'Sjoen G.G. (November 2017). Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline. J Clin Endocrinol Metab, 102(11):3869–3903 doi: 10.1210/jc.2017-01658, p. 3886; and: Coleman E., Radix A. E., Bouman W.P., Brown G.R., de Vries A. L. C., Deutsch M. B., Ettner R., Fraser L., Goodman M., Green J., Hancock A. B., Johnson T. W., Karasic D. H., Knudson G. A., Leibowitz S. F., Meyer-Bahlburg H. F.L., Monstrey S. J., Motmans J., Nahata L., ... Arcelus J. (2022). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. International Journal of Transgender Health, 23(S1), pp.S1-S260. https://doi.org/10.1080/26895269.2022.2100644, pp. 119 and 254-257; Hansen M.V. , Giraldi A., Main K.M., Tingsgård J.V., Haahr M.E. (3-07-2023). Ugeskrift for Læger . Sundhedsfaglige tilbud til børn og unge med kønsubehag. https://ugeskriftet.dk/videnskab/sundhedsfaglige-tilbud-til-born-og-unge-med-konsubehag.

approach alone, based on WPATH standards or the Dutch Protocol - the riskiest, most invasive approach with the weakest theoretical and empirical foundation. It is also worth providing information about the difficulties in accessing reliable information in the public space especially for outsiders, which can intensify their confusion. A written acknowledgment of having been informed of these details is recommended.

We advocate that, following internal consultations and deliberations, the interdisciplinary team should present to the family the possible and recommended comprehensive and **individualized forms of assistance** tailored to the specific child and their environment (e.g., psychiatric help, psychotherapy - group, individual, family, play therapy for young children, interpersonal training, environmental interventions, cooperation with school staff, parents' psychotherapy, assistance from other specialists, etc.). If possible, the entire family system should be included in the assistance. We recommend that the proposed therapy be comprehensive and also directed at other accompanying problems.

Psychotherapy

In therapy, the primary focus should be on addressing existing mental health issues and family system disorders. Therefore, psychotherapy[113] should be at least the first option[114] of choice. Psychotherapy should be anchored in diagnostic findings (helpful questions are in the sections concerning diagnostics). Psychotherapy also allows for at least delaying irreversible decisions until greater emotional maturity is achieved without being committed with finality to one or another choice. A good starting point for a psychotherapeutic contract is to examine the patient's motivation in wanting to be of the opposite sex and ensuring conscious decision-making and insight into personal motivations regarding gender perception and future plans (not neutralizing existing fears with transition fantasies helps in exploring and getting to know oneself). Assistance is offered to help the child "feel better in their skin." "The goal becomes uncovering motives, beliefs, and understanding the role of gender dysphoria in their overall functioning and looking beyond the fixation of the mind - at underlying conflicts, doubts, and fears - with empathy and understanding for the patient. Equally important is learning to tolerate uncertainty, doubt, or confusion, and a realistic assessment of what is and is not possible"[115]. Psychotherapy can help

113 An overview of 19 studies on the use of psychotherapy in the case of G.I.D. is provided on the SEGM website, in the tab "Studies" (https://segm.org/studies).

114 A vague suggestion: "at least" refers to situations with varying degrees and quality of legal regulation. As argued above, we are clearly against social, medical or legal transition for people who are at least minors, or even better until their identity and personality are formed. In adults, gender identity disorders do not change their genesis or nature, only the degree of their consolidation may change. Medical transitions/sex neutralization cause legal, medical and social chaos and carry comprehensive medical risks.

115 Marianowicz-Szczygieł A., Review of 22 standards and models of assistance for children and adolescents with gender identity disorders - recommendations for the Polish model, chapter: „Therapeutic model of M. and S.Evans", *in press*. Quote: 'The transgender identity is supposed to be a kind of defensive fantasy by building an

explore many aspects of a child and young person's life, uncover them, give them meaning and significance, and is therefore often called exploratory psychotherapy[116]. It especially allows for addressing the relief from suffering and a painful life, siding with the child, and providing much-needed support. The list of detailed therapeutic areas is long and should be individualised.

In addition to deepening diagnostic questions, we recommend a detailed examination of:

a) the possibility of reactive symptoms of gender identity disorders,

b) the presence of neurotic mechanisms and symptoms of earlier developmental deficits or educational mistakes, and also

c) the effect of identity problems related to puberty,

d) the effect of cultural influences. Special attention should be paid to:

Ref. a) the possible reactivity of symptoms of gender identity disorders - reactions to traumas, fears of intercourse, being frightened by brutal pornography, reactions to failures in relationships with the opposite sex, anxiety symptoms related to one's body and puberty, reactions to other mental crises, including developmental ones,

Ref. b) the potential presence of neurotic mechanisms and symptoms of earlier developmental deficits or educational misinformation from educators, educational failures: the consequent effects of trying to escape from overwhelming suffering, the effect of "emotional freeze," suppression of fears and depression; gender identity disorders as a symptom of self-destruction, social isolation and confinement in an "internet dungeon," alienation from masculinity, femininity, lack of positive male or female models, inducing reversed gender identity in the upbringing process (e.g., dressing boys as girls), satisfying the need for belonging and acceptance through gender dysphoria, escaping from failures, boredom in this way), a way to utopian "superpower" (thinking like: "you are who you say you are because you know best who you are"), the effect of seeking simple solutions to complicated problems (thinking like "there must be a pill for this"), reactions to lack of boundaries in upbringing,

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illusory, ideal ego into which young people are pushed by difficult circumstances and conflict-generating relationships: trauma 'scares' them with mental catastrophe (e.g. parents' divorce, rejection by a parent). Therefore, the sensitive ego is afraid of falling apart under the influence of psychological pain, and a transgender ideal ego is built. The strategy: "if only I were (a boy / a girl), all my problems would be solved" is burdened with an astonishing 100% certainty, which, according to M. Evans, should be a warning (and a hallmark) sign, indicating the disappearance or limitation of critical thinking, as symptom of waking fantasy. Even more so because children and adolescents with transgender problems are characterised, according to Evans, by a general increased susceptibility to blurring the line between dreams and reality, and a tendency to fantasize. This is where the false certainty that specific and radical therapies will quickly solve their problems arises, and a kind of omnipotence of thinking appears.'

116 There are two types of exploratory therapy: GET (Gender Exploratory Therapy) and CET (Change Exploratory Therapy), which can be described as GET therapy combined with openness to seeking acceptance of one's body , in accordance with the goals of the client and his family); See: Gender Exploratory Therapy Association (2022). *A Clinical Guide for Therapists Working with Gender-Questioning Youth Version 1*, https://www.genderexploratory.com/wp-content/uploads/2022/12/GETA_ClinicalGuide_2022.pdf

Ref. c) the possible effect of identity problems related to puberty: an antidote to transient identity confusion, transient developmental "formlessness," treating the gender area as new territory for rebellion, a sense of uniqueness, escape "from the hell of puberty," the default option in case of developmental doubts, a kind of ready-made social identity, even without a diagnosis, the effect of fashion, fitting in with the environment, the desire to stand out in the environment (youthful competitions for originality), and finally the influence of the group (peer contagion),

Ref. d) possible cultural influences: the effect of dealing with unjust stereotypes about feminity and masculinity, especially those that are harmful, and reaction to the cultural crisis of femininity, masculinity, defence against perceiving oneself as not perfect enough (cultural pressure for a perfect body, perfect lifestyle).

A specific task for the psychiatrist in the interdisciplinary team is to provide ongoing pharmacological support if needed.

The assistance process should emphasize **addressing any developmental deficits** - propose participation in social skills, assertiveness, communication, etc., training, and addressing **relational or family deficits** (building close relationships within the family).

The earlier Gender Identity Disorder (G.I.D.) is diagnosed, the higher the likelihood of an accurate therapeutic intervention.

In extreme cases, it may be necessary **to consider a radical change in the child's environment**, especially the virtual one. Strong social ostracism and psycho manipulation mechanisms, known from the functioning of sects[117], have been described in youth subcultures that encourage medical transition, including persuading them to isolate from supposedly toxic families and replace them with a transgender family, the so-called "glitter" family[118]. It is important that the above change in environment is appealing to the adolescent[119]. However, in every case, a parent should monitor the adolescent's online activity (without violating privacy) and establish appropriate boundaries and limits[120].

During the consultation meeting about the proposed assistance path with the child/young person and their family, discuss concerns and challenges related to the proposed form of assistance, examine the overall motivation within the entire family and the patient themselves, and then, after obtaining approval for the forms of assistance (also optimally in written form) - establish a schedule and convenient form of meetings.

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117 Shrier A. (2023). Nieodwracalna krzywda. Kraków: Dystrybucja AA, p. 280 and others.- pp. 140, 278. Quote translated from Polish text: ''In the transgender social circles that Benji and Erin frequented, testosterone was the currency and breast surgery was the coat of arms.'

118 *Ibidem,* p.99.

119 *Ibidem*. The author gives examples of moving out, a year-long sabbatical leave used to travel around the world, or working on a horse farm without access to the Internet. It is also worth considering committed volunteering consistent with the child's interests, and besides, if necessary, changing schools.

120 Websites that may be of help (in Polish): rodzice.co; pytam.edu.pl, sos.pytam.edu.pl, zatroskani.pl.

It is advisable for the interdisciplinary team to regularly discuss progress and challenges in professional assistance, and a more detailed assessment of the patient and their family should take place approximately every quarter. It's essential to continuously monitor mental health, especially suicidality (direct questions), and physical health (an important element is BMI control and targeted prevention of both underweight and obesity)[121].

An essential part of assistance is **general psycho-prophylaxis** - building good relationships with the child through significant people, strengthening self-worth not related to gender, ensuring satisfying social contacts, including with peers and adults of both sexes, developing interests and character training, and spiritual development (sports, scouting, pastoral care, etc.). Such activities should involve the child's environment as broadly as possible.

Thus, we stand on a foundation solidified by the rigors of scientific knowledge and clinical experience, and at the same time, a pragmatic, holistic, and long-term position, and above all, we are guided by the comprehensively understood good of the child. Since there have been no Polish standards for diagnostic and therapeutic procedures for children with gender identity disorders or the suspicion thereof, we have developed this document in the spirit of concern for the future generations. We hope it will open an objective and calm discussion, proving useful for specialists and political decision-makers. The wave of pressure to jump as quickly as possible onto the "transition procedure is the only correct" bandwagon could end in even greater suffering for many children and young people, massive trauma for their loving families, and an endless wave of lawsuits and loss of trust towards professionals who participated in this.

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121 Both being underweight and overweight contributes to a negative self-image, especially in the teenage years, and there is also evidence that they are associated with gender dysphoria. 1. 46.1% of adolescents were either overweight or obese at their first pediatric visit for gender dysphoria. 2. 50.5% of the surveyed "TGD youth" had a BMI >85%, 30.3% had a BMI >95%, and 3.6% were underweight (BMI <5%) – Sources: [Ad.1.] Moser C.N., Fornander M.J., Roberts C.M., Egan A.M., Robertson G. (2023). Body Mass Index Categories of Transgender and Gender Diverse Youth: Clinical Associations and Predictors. *Child Obes*. Jun 30. doi: 10.1089/chi.2023.0021. Epub ahead of print. PMID: 37389851, [Ad.2.] Fornander M.J., Roberts T., Egan A.M., Moser C.N.. Weight status, medication use, and recreational activities of treatment-naïve transgender youth. *Child Obes*. 2022 Jun,18(4), pp.228-236. doi: 10.1089/chi.2021.0155. Epub 2021 Nov 11. PMID: 34762510.