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

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Many thanks for help in preparing the guidelines to all those and other experts not mentioned here who contributed to the creation of this document with their advice and valuable comments, time and practical help, but wished to remain anonymous.

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

The document was also created with the support of the Foundation Institute of Analysis of Sex and Sexuality “She and He” (**www.onaion.org.pl**).

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 (Singapore, Malaysia, Thailand, Philippines and Vietnam)

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

These "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

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 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

This document, called 'SPCh Standards 2024' for short was created in several stages based on the first Polish version from 2023, which had the status of "Draft for public consultations". In the current version, we have tried to take into account the comments that we have received, clarify certain concepts, and, above all, update and significantly enrich the bibliography, especially in the area of health, and slightly supplement the psychotherapeutic guidelines and methodological framework. Its final 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 second version of this document, extremely needed not only in Poland, filling an important gap in professional knowledge and clinical practice[1]. Organizational and technical data as well as references to the quality assessment system of professional guidelines AGREE II (The Appraisal of Guidelines for Research & Evaluation) are included in the Annex. We also encourage readers to send professional opinions that will contribute to improving the document in the future (please contact us through spch.pl website, where current versions of the document are also available).

1 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 al. (2021). Zalecenia Polskiego Towarzystwa Seksuologicznego dotyczące opieki nad zdrowiem dorosłych osób transpłciowych - stanowisko panelu ekspertów. *Psychiatr. Pol.* 55(3), pp. 701–708 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.

CHAPTER 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 intellect and freedom (in the case of children, age-appropriate) – 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 sex/gender is not a 'state of mind', but a binary biological reality, functional for the process of sexual reproduction. Biological indicators of masculinity and femininity (understood in the context of reproductive abilities) are sex chromosomes, gonads, sex hormones and unambiguous (male or female) internal and external sex organs[2]. Almost every cell in our body[3] is sexually differentiated. Men's and women's bodies differ in many anatomical and physiological aspects, even in some ways that are invisible to the naked eye[4].

Although there are also some statistically significant psychological differences between the sexes[5] [6] [7], there is no doubt that sex is biological, while there are secondary psychological (gender identification – gender self-perception) and cultural and social (gender roles – gender expression) aspects that follow (in the Polish language, "sex" and "gender" are expressed by one and the same uniting word). Subjective mental identification/gender identification (multi-variant and labile) cannot change biology (fixed), because subjective perception does not have the power to change physical reality ("the body is me"). For this reason, in the process of medical transition, sex may only undergo partial, artificial modification (feminization or masculinization of appearance), but cannot change. Sex chromosomes in body cells do not change, and it is not possible to transform male gonads (testes) into female gonads (ovaries) and vice versa (it is possible to remove the gonads surgically, however, leading to infertility and not to actual sex change in terms of reproductive capacity)[8].

The extremely small group of so-called intersex people, i.e. those suffering from disorders/ differences of sex development (DSD), in whom it is not possible to clearly determine the sex based on phenotypic features (the appearance of the genital organs), does not constitute a "third sex" because there is no other, alternative way of reproduction (there are no reproductive cells other than male and female), so this disorder is a deviation from the

2 See: American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Arlington, VA: American Psychiatric Association, p. 829.

3 To be precise, "every nucleated somatic cell", which constitutes the vast majority of cells. An example of an exceptionis that erythroctes (red blood cells) in humans do not have nuclei.

4 As a result, there are gender-dependent differences in susceptibility to diseases and the clinical course of cardiovascular diseases, cancers, metabolic disorders, autoimmune diseases, and neurological diseases (including neurodegenerative ones). Shi Y., Ma J., Li S. et al. (2024). Sex difference in human diseases: mechanistic insights and clinical implications. *Signal Transduction and Targeted Therapy* 10; 9(1), 238. DOI: 10.1038/s41392-024-01929-7

5 Hyde J.S., Frost L.A.(2004). Metaanalizy w psychologii kobiety. in: Wojciszke B. [ed.] *Kobiety i mężczyźni: odmienne spojrzenie na różnice*. Gdańsk: Gdańskie Wydawnictwo Psychologiczne, pp. 15-47; see especially tab. on pp. 21-24 with a summary of the results of psychological research in the field of sex differences in cognitive activities.

6 Brandes C.M., Kushner S.C., Herzhoff K. et al. (2021). Facet-level personality development in the transition to adolescence: Maturity, disruption, and gender differences. *J Pers Soc Psychol, 121*(5), pp.1095-1111. https://pubmed.ncbi.nlm.nih.gov/33180545/

7 Joshi P. D., Wakslak C. J., Appel G. et al. (2020). Gender differences in communicative abstraction. *Journal of Personality and Social Psychology*, *118*(3), pp. 417–435. https://psycnet.apa.org/doiLanding?doi=10.1037%2Fpspa0000177

8 Departure from biological reality leads to absurdities and paradoxes, for example, 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 in Shier A. [2023]. Nieodwracalna krzywda. Kraków: Dystrybucja A.A., p.229; translation of the quote from the book by the Polish; English title: *Irreversible Damage*.

common pattern. These disorders are extremely rare, estimated at 0.022% [9] or 0.018%[10]. In the vast majority of cases of people with DSD (e.g. people with Turner syndrome, Klinefelter syndrome, cryptorchidism or hypospadias) the identity of the gender as biologically male or female is clear.

9 „Abnormalities of the external genitalia sufficient to warrant genetic and endocrine studies occur in one in 4500 births"; this is approximately 0.022%. Source: Hughes I.A., Nihoul-Fékété C., Thomas B. et al. (2007). Consequences of the ESPE/LWPES guidelines for diagnosis and treatment of disorders of sex development. *Best Pract Res Clin Endocrinol Metab* Sep;*21(3)*, pp. 351 - 365. doi:10.1016/j.beem.2007.06.003.

10 „If the term intersex is to retain any meaning, the term should be restricted to those conditions in which chromosomal sex is inconsistent with phenotypic sex, or in which the phenotype is not classifiable as either male or female. Applying this more precise definition, the true prevalence of intersex is seen to be about 0.018%". Source: Sax L. (2002). How common is intersex? A response to Anne Fausto-Sterling. *J Sex Res* 39 (3), pp. 174-178. DOI: 10.1080/00224490209552139

CHAPTER 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. Longitudinal data from health registers in the Netherlands[11], Denmark[12] and Sweden[13],
2. Statement of the European Society of Child and Adolescent Psychiatry (ESCAP) – a federation of 36 national psychiatric associations[14]
3. Report from the Swedish state agency SBU from December 2019, commissioned by the Swedish government (SBU 2019/427)[15],
4. An independent British report, known as the "Cass review", commissioned by the National Health Service in England - NHS England (2024)[16], (2022)[17],
5. Two reports from the National Institute for Health and Care Excellence (NICE) commissioned by the National Health Service in England - NHS England (14.10.2020)[18] and (21.10.2020)[19],
6. International Federation of Therapeutic and Counselling Choice (9.03.2023) " IFTCC Principles for Approaches to Transgender Treatments"[20],

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11 de Blok C.J.M., Wiepjes C.M., van Velzen D.M. et al. (2021). Mortality trends over five decades in adult transgender people receiving hormone treatment: a report from the Amsterdam cohort of gender dysphoria. *The Lancet Diabetes & Endocrinology* 9, pp.663-670. DOI: 10.1016/S2213-8587(21)00185-6

12 Glintborg D., Møller J.J.K., Rubin K.H. et al. (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; See: Glintborg D., Rubin K., Kristensen S. et al. (2022). Gender affirming hormonal treatment in Danish transgender persons. A nationwide register-based study. *Andrology. 10 (3)* DOI: 10.1111/andr.13181

13 Dhejne C., Lichtenstein P., Boman M. et al. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLoS ONE*, 6(2), e16885. https://doi.org/10.1371/journal.pone.0016885

14 Radobuljac M.D., Grošelj U., Kaltiala R., the ESCAP Policy Division, the ESCAP Board et al. (2024). ESCAP statement on the care for children and adolescents with gender dysphoria: an urgent need for safeguarding clinical, scientific, and ethical standards. *European Child & Adolescent Psychiatry*, 33, pp.2011–2016. https://link.springer.com/article/10.1007/s00787-024-02440-8

15 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/

16 Cass H. (04.2024). *The Cass Review. Independent review of gender identity services for children and young people. Final report*. https://cass.independent-review.uk/wp-content/uploads/2024/04/CassReview_Final.pdf from: https://cass.independent-review.uk/home/publications/final-report/

17 Cass H. (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

18 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

19 N.I.C.E. (21.10.2020). *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

20 IFTCC (9.03.2023). IFTCC Principles for Approaches to Transgender Treatments. https://learning.iftcc.org/principles-of-transgender-treatments/. Polish translation: http://onaion.org.pl/2023/06/30/miedzynarodowe-wytyczne-w-kwestiach-transgenderowych/

7. 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[21],
8. Position of the French National Academy of Medicine dated 25.02.2022[22],
9. Report and statement of The Florida Department of Health[23 24],
10. Position of the American College of Pediatricians [25 26],
11. Position of the governmental agency COHERE Finland (16.06.2020)[27],
12. Guidelines of the Gender Exploratory Therapy Association (2022)[28],
13. Guidelines of National Association of Practising Psychiatrists, Australia (18.03.2022)[29],
14. Position of the Royal Australian and New Zealand College of Psychiatrists - December 2021[30],
15. Position of the Norwegian Healthcare Investigation Board - UKOM from March 2023[31],
16. Open letter from Genspect and 3558 parents to members of the American Academy of Pediatrics (Genspect 18.02.2022)[32],
17. Model used in the Gender Identity Service at the Centre in Canada[33],

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21 Royal Courts of Justice (1.12.2020). Q. Bell and Mrs A. versus Tavistock and Portman NHS Foundation Trust. Case No. CO/60/2020. https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf

22 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

23 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

24 Florida Agency for Healthcare Administration (June 2022). Florida Medicaid Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria. https://ahca.myflorida.com/content/download/4869/file/AHCA_GAPMS_June_2022_Report.pdf

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

26 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

27 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

28 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

29 National Association of Practicing Psychiatrists (18.03.2022). Managing gender dysphoria/incongruence in young people: a guide for health practitioners. https://napp.org.au/2022/03/managing-gender-dysphoria-incongruence-in-young-people-a-guide-for-health-practitioners-2/

30 Royal Australian and New Zealand College of Psychiatrists (12.2023). Position statement no. 103: "The role of psychiatrists in working with Trans and Gender Diverse people". https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/gender-dysphoria.

31 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*, 380, p. 697 http://dx.doi.org/10.1136/bmj.p697 https://www.bmj.com/content/bmj/380/bmj.p697.full.pdf

32 Genspect (18.06.2022). An Open Letter to the American Academy of Pediatrics – Genspect. https://genspect.org/an-open-letter-to-the-american-academy-of-pediatrics/; Polish translation on the website "She and He" Institute: http://onaion.org.pl/list-rodzicow-dzieci-z-zaburzeniami-plci/

33 Zucker K.J., Wood H., Singh D. et al. (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

18. Model of Marcus and Susan Evans (2020)[34], (2021)[35],

19. Based on Polish publications[36 37 38 39 40],

20. Based on data regarding detransition[41 42 43 44 45 46 47 48 49],

21. Based on international reviews of professional guidelines and positions (review of

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34 Evans M. (2020). Freedom to think: the need for thorough assessment and treatment of gender dysphoric children. *BJ Psych 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

35 Evans M. and S. (2021). *Gender Dysphoria. A Therapeutic Model for Working with Children, Adolescents and Young Adults*. Bicester: Phoenix Publishing House.

36 Kmieciak B., & Sobczyk P. [eds.] (2021). *Między chromosomem, a paragrafem. Transseksualizm w ujęciu prawno-społeczno-medycznym*, pp. 93-142, Warsaw: Wydawnictwo Instytutu Wymiaru Sprawiedliwości.

37 Fajkowska M. (2001). Transseksualizm i rodzina: Przekaz pokoleniowy wzorów relacyjnych w rodzinach transseksualnych kobiet. Warsaw: Wydawn. Instytutu Psychologii Polskiej Akademi Nauk, Szkoła Wyższa Psychologii Społecznej

38 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

39 Smyczyńska J. (2023). Medical care for children and adolescents with gender dysphoria and gender inconsistency in the light of current recommendations - how to implement the „primum non nocere" principle? *Kwartalnik Naukowy Fides et Ratio*, no 3(55), pp.1-21. https://doi.org/10.34766/fetr.v55i3.1220

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

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

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44 Hall R., Mitchell L., Sachdeva J. (2021). Access to care and frequency of detransition among a cohort discharged by a UK national adult gender identity clinic: Retrospective case-note review. *BJ Psych Open,* 7(6), E184. https://www.cambridge.org/core/journals/bjpsych-open/article/access-to-care-and-frequency-of-detransition-among-a-cohort-discharged-by-a-uk-national-adult-gender-identity-clinic-retrospective-casenote-review/3F5AC1315A49813922AAD76D9E28F5CB

45 Expósito-Campos P. (2021). A typology of gender detransition and its implications for healthcare providers. *Journal of Sex & Marital Therapy,* 47(3), pp. 270-280. https://www.tandfonline.com/doi/full/10.1080/0092623X.2020.1869126#d1e193

46 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

47 Heyer W. (2018). *Trans Life Survivors*. Walt Heyer.

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

49 Due to the early stage of research on detransition, media reports rich in important details also have some clinical value: 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/; Sakowski Ł. (5.04.2023). Moja historia cofnięcia zmiany płci. Tranzycja i detranzycja. Łukasz Sakowski. To tylko teoria.pl. https://www.totylkoteoria.pl/tranzycja-detranzycja-zmiana-plci/; Afirmacja tv. (27.09.2026). Ignorancja lekarzy i słodkie kłamstwa w sieci. Zobacz świadectwo Magdy zmanipulowanej do tranzycji. https://www.youtube.com/watch?v=81Js9QtlX1s; Marianowicz-Szczygieł A. (21.02.2023). Detranzycja. Oni żałują „zmiany płci". Afirmacja.info. https://afirmacja.info/2023/02/21/detranzycja-oni-zaluja-zmiany-plci/; 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/

23[50] clinical guidelines, 12 clinical practice guidelines[51], 24 guidelines and professional positions[52]) and findings on thematic scientific consensus[53 54],

22. Review "Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria", The Linacre Quarterly[55],
23. Thematic professional literature review at statsforgender.org[56],
24. Literature review by the Society of Evidence-Based Gender Medicine (SEGM)[57].

The purpose of this document is to provide tangible and practical help for clinicians who work with children and adolescents reporting problems with gender identification, for their families and their immediate environment. The document provides scientific knowledge, proposes detailed guidelines for differential diagnosis and psychological diagnosis, and specific guidelines for psychotherapy and medical assistance. It also formulates conclusions for public policies.

There is a great diversity of positions around the world on professional assistance in area of helping children and youth with gender identity concerns. In our opinion, it results not so much from the lack of scientific evidence, although this is a relatively new area of emerging evidence that should be constantly supplemented, but from the lack of interdisciplinary integration of existing evidence.

Some particular challenges in forming standards and guidelines is the array of interdisciplinary perspectives and the need to avoid the medicalization of problems of a predominantly psychological origin. As a result, many international guidelines, although based on scientific evidence, make methodological errors and either ignore available psychological evidence or are ambiguous, transferring the responsibility for the decision on the mode of therapy to specific clinicians or families, although, of course, an individualized approach is always highly advisable. These standards are of a psychological - medical nature, unlike the medical or medical-psychological standards that have until recently dominated in the world.

Three very different professional approaches have developed in the world: passive (which is not neutral), affirming the child's gender identification (and therefore the young person's self-diagnosis) and a more cautious and balanced approach: "psychotherapy first" based on the classic cause-and-effect model of science (endeavoring to diagnose and treat the cause), which is closest to the approach that is in line with our views. Gender identity is part of an identity, part of personality, which is the object of psychological research. That is

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50 Taylor J., Hall R., Heathcote C. et al. (2024). Clinical guidelines for children and adolescents experiencing gender dysphoria or incongruence: a systematic review of guideline quality (part 1). *Arch Dis Child,* Apr 9:archdischild-2023-326499. doi: 10.1136/archdischild-2023-326499.

51 Dahlen S., Connolly D., Arif I. et al. (2021). International clinical practice guidelines for gender minority/trans people: systematic review and quality assessment. *BMJ Open* 11:e048943. doi: 10.1136/bmjopen-2021-048943

52 Marianowicz-Szczygieł A. A review of 24 professional standards, positions and models of helping children and young people with gender identity problems. Conclusions for the Polish model. In press.

53 Block J. (2023). Gender dysphoria in young people is rising-and so is professional Disagreement. *BMJ* 380, p. 382. http://dx.doi.org/10.1136/bmj.p382

54 Strang J. F., Meagher H., Kenworthy L., et al. (2016). Initial clinical guidelines for co-occurring autism spectrum disorder and gender dysphoria or incongruence in adolescents. *Journal of Clinical Child & Adolescent Psychology*, 47(1), pp. 105–115. https://doi.org/10.1080/15374416.2016.1228462

55 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

56 STATSFORGENDER.ORG. *Gender at your fingertips.*

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

why general theories on the development of identity as such, such as Erik Erikson's theory of development[58], James Marcia's[59] ego identity development, or Vivian L. Vignoles'[60] [61] motivated identity construction theory and others, contribute so much to understanding the phenomenon of gender identity disorders. The main axis of the popular so-called affirmative approach in the professional space are the WPATH standards, the Dutch Protocol and the guidelines of endocrinological societies, which do not investigate gender identity from a psychological perspective and are not adapted to the new and currently numerically dominant clinical group, which will be discussed below.

The assumptions of leading guidelines in the affirming trend (e.g., the Dutch Protocol[62] [63], WPATH standards - versions 7[64] and 8[65], Endocrine Society standards[66]) have been criticized[67] [68] [69] as being based on evidence of low or very low quality (please see also chapter IV paragraph 9) according to the GRADE[70] evaluation system. Such therapies are referred to by some experts as experimental.

Moreover, data coming from the "affirmative care" approach are highly compromising for rapid and uncritical transition of minors and even for pseudoscientific and ideological

58 Erikson E. H. (1968). *Identity, Youth and Crisis*. New York: Norton.

59 Marcia J. E. (1966). Development and validation of ego-identity status. *Journal of Personality and Social Psychology*, 3(5), pp. 551–558. DOI:10.1037/h0023281; See also: Bardziejewska M. (2021). Okres dorastania. Jak rozpoznać potencjał nastolatków? in: Brzezińska A. I. [ed.]. *Psychologiczne portrety człowieka: praktyczna psychologia rozwojowa*, pp. 345–77. Gdańsk: Gdańskie Wydawnictwo Psychologiczne.

60 Vignoles V.L., Regalia C. Manzi C. et al. (2006). Beyond self-esteem: influence of multiple motives on identity construction. *Journal of Personality and Social Psychology* 90(2), pp.308-933 DOI:10.1037/0022-3514.90.2.308

61 Vignoles V., Schwartz S., Luyckx K. (2011). *Introduction: toward an integrative view of identity*. 10.1007/978-1-4419-7988-9_1.; According to motivated identity construction theory people shape their identity to satisfy basic motivations for distinctiveness, continuity, self-esteem, belonging, efficacy and meaning.

62 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

63 Dora M., Grabski B., Dobroczyński B. (2020). Dysforia płciowa i nonkonformizm płciowy w adolescencji – zmiany i wyzwania diagnostyczne, *Psychiatria Polska*, *162*. s. 1–15. https://doi.org/10.12740/PP/OnlineFirst/113009.

64 WPATH-7: WPATH (2012). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. 7-th Version. https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf

65 WPATH-8: Coleman E., Radix A.E., Bouman W.P. et al. (2022). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, *International Journal of Transgender Health*, *23*(1), pp.1–259; DOI:10.1080/26895269.2022.2100644;

66 Hembree W.C., Cohen-Kettenis P.T., Gooren L. et al. (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

67 Block J. (23.02.2023). Gender dysphoria in young people is rising—and so is professional disagreement. *BMJ* 380, p382; doi: https://doi.org/10.1136/bmj.p382

68 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 Therapy*. DOI:10.1080/0092623X.2022.2150346

69 Biggs M. (2022). The Dutch Protocol for juvenile transsexuals: origins and evidence. *Journal of Sex & Marital Therapy*. DOI:10.1080/0092623X.2022.2121238

70 BMJ (2024). What is GRADE? BMJ best practice. https://bestpractice.bmj.com/info/toolkit/learn-ebm/what-is-grade/

pressure to transition young people[71 72 73 74]. Summa summarum, already in 13 countries steps have been taken to withdraw from the affirmative approach or move to a more balanced and cautious position. These changes are being taken at the level of national or state law, national health care, administrative regulations and positions of influence in professional organizations. The most advanced in terms of preventing or limiting the transition of minors are the USA (changes in the law currently pending in 43 states, 45 bills passed)[75 76], Sweden (see source in paragraph 3 above), Finland (paragraph 12), Norway (paragraph 15), Great Britain (paragraphs 4,5,7), Hungary[77] and Denmark[78 79]. In France (see paragraph 8), Australia (paragraphs 14 and 16), New Zealand (paragraph 16), Italy[80], Germany and Switzerland[81] and hereby in Poland - opinion-forming professional environments appeal for caution. The position of ESCAP[82] - an international federation of 36 national societies and departments of child psychiatry in Europe - is particularly significant. The world's leading media have written about the steps away from gender-affirming policies for minors and the disturbing methods that have been used in diagnosis and treatment: *Forbes*[83], *Reuters*[84],

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71 Hughs M. (2024). The WPATH Files. Pseudoscientific surgical and hormonal experiments on children, adolescents, and vulnerable adults. Environmental Progress. https://static1.squarespace.com/static/56a45d683b0be33df885def6/t/65e6d9bea9969715fba29e6f/1709627904275/U_WPATH+Report+and+Files.pdf ze strony: https://environmentalprogress.org/big-news/wpath-files.

72 Reed J. (9.02.2023). I thought i was saving trans kids. now i'm blowing the whistle. The Free Press. https://www.thefp.com/p/i-thought-i-was-saving-trans-kids

73 Kaltiala R. (30.10.2023). 'Gender-affirming care is dangerous. i know because i helped pioneer it.' https://www.thefp.com/p/gender-affirming-care-dangerous-finland-doctor

74 Cooke R. (2.05.2021). Tavistock trust whistleblower David Bell: 'I believed I was doing the right thing'. The Guardian. https://www.theguardian.com/society/2021/may/02/tavistock-trust-whistleblower-david-bell-transgender-children-gids

75 https://translegislation.com/

76 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.

77 *Rzeczpospolita* (20.05.2020). Węgry zakazują legalnej zmiany płci. https://www.rp.pl/spoleczenstwo/art711691-wegry-zakazuja-legalnej-zmiany-plci.

78 SEGM (17.08.2023). Denmark joins the list of countries that have sharply restricted youth gender transitions. https://segm.org/Denmark-sharply-restricts-youth-gender-transitions See: Ingerslev L. (1.06.2023). Opsigtsvækkende gode nyheder: Sundhedsministeren lover stop for kønsskifte til børn med pludselig opstået kønsdysfori (ROGD) samt stop for kirurgisk kønsskifte til børn under 18 år https://www.transkoen.dk/2023/06/01/opsigtsvaekkende-gode-nyheder-sundhedsministeren-lover-stop-for-koensskifte-til-boern-med-pludselig-opstaaet-koensdysfori-rogd-samt-stop-for-kirurgisk-koensskifte-til-boern-under-18-aar/ Por. https://ugeskriftet.dk/videnskab/sundhedsfaglige-tilbud-til-born-og-unge-med-konsubehag

79 Hansen M.V., Giraldi A., Main K.M. i in. (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.

80 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. Buttons C. (30.01.2023). Italian Psychological Association expressed "great concern" over puberty blocking drugs. *The Daily Wire*. https://www.dailywire.com/news/italian-psychological-association-expressed-great-concern-over-puberty-blocking-drugs?inf_contact_key=5f4f5a2dc69a3b2e9ba1748470b5556bb7af0999dac2af6212784c39e05d2aef

81 Kröning A. (12.06.2024). Ärzte-Verbände wenden sich gegen eigene „Transkinder"-Behandlungsleitlinie. *Welt*. https://www.welt.de/politik/deutschland/article251937014/Fachgesellschaften-wenden-sich-gegen-eigene-Transkinder-Behandlungsleitlinie.html. See the protest of 15 mental health specialists on 24.05.2024: Gemeinsame Kommentierung des aktuellen Entwurfs der neuen S2k-Leitlinie „Geschlechtsinkongruenz und Geschlechtsdysphorie im Kindes- und Jugendalter" https://www.zimannheim.de/fileadmin/user_upload/downloads/forschung/KJP_downloads/Gemeinsame_Kommentierung_Leitlinienentwurf_S2k-240521.pdf

82 Radobuljac M.D., Grošelj U., Kaltiala R., the ESCAP Policy Division, the ESCAP Board et al. (2024). ESCAP statement on the care for children and adolescents with gender dysphoria: an urgent need for safeguarding clinical, scientific, and ethical standards. *Op.cit.*

83 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/

84 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/.

Euronews[85], *The Atlantic*[86], *CBN*[87] or *The Guardian*[88].

In these guidelines, while respecting the autonomy of the child or young person and his family, we propose the best model of assistance in our opinion and we advocate for a comprehensive, integrated, interdisciplinary, approach that utilizes, among other things, the findings of developmental psychology, psychology of personality, clinical and family psychology, and non-invasive, what we believe to be safer, and scientifically well-grounded methods.

85 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.

86 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/.

87 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=IwAR0XJLnH44P6tSDZ0nvUuFvAfaPJAXI0U1YmR4Be6E6mmwecMPL4-F3w2pY.

88 Batty D. (30.07.2004). Sex changes are not effective, say researchers. *The Guardian*. https://www.theguardian.com/society/2004/jul/30/health.mentalhealth.

CHAPTER 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 research findings 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, these disorders are mostly acquired, not congenital [89] [90] [91] [92] [93] [94] [95] [96] [97]. The context of the civilizational crisis of identity and "lack of roots" also appears to be a significant vantage point for research.

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'[98] - is, we think, a misguided approach. It simplifies the complicated matter of gender identity dysfunction to individuals' subjective declarations, essentially neglecting, if not preventing, diagnosis of possible predisposing or underlying causal disorders and depriving individuals of appropriate treatment and public health care rights to treatments alternative to body-altering and harming approaches. It also implies at the same time the elimination of sex (in biological terms), replacing it with

89 Cass. H. (2024). The Cass Review. Independent review of gender identity services for children and young people. The final report. *Op.cit.*, chapter 8, pp. 114-121.

90 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

91 Lee P.A., Nordenström A., Houk C.P et al. (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

92 Becerra-Culqui T.A., Liu Y., Nash R. et al. (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.

93 Bechard M., VanderLaan D.P., Wood H., et al. (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

94 Kozlowska K. McClure G., Chudleigh C., et al. (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 See: Elkadi J., Chudleigh C., Maguire A.M. et al. (2023). Developmental pathway choices of young people presenting to a gender service with gender distress: A prospective follow-up study. *Children*, 10, 314, pp.1-24. https://doi.org/10.3390/ children10020314

95 Thrower E., Bretherton I., Pang K.C. et al. (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

96 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, Warsaw: Wydawnictwo Instytutu Wymiaru Sprawiedliwości

97 Wieczorek B. (2018). *Homoseksualizm. Przegląd światowych analiz i badań. Przyczyny, objawy, terapia, aspekty społeczne*. Warsaw: Fronda, chapter about GID.

98 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

terms like 'assigned sex' or 'experienced gender'[99]. We believe it is equally flawed to use a subjective distress criterion [100] in the definition of 'gender dysphoria' as the main criterion, as is the case in DSM-5, DSM-5-TR, and ICD-11. Therefore, we prefer the term 'gender identity disorders', abbreviated **'GID'. Our proposal concerns changes in terminology as well as diagnostics and therapy, not the denial of the phenomenon itself**. Instead of a focus on 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 drastic outcomes for individuals, evidenced by the increasing number of detransition testimonies and procedures. These point to fundamental errors in diagnostic procedures and an overly casual branding with the label of 'transexualism' by some in the healthcare community.

3. Gender identity disorders in children and adolescents most often resolve spontaneously in 73% - 98% of cases[101] [102] [103] [104] [105] [106] 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 (please see below).

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[107] [108], 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

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99 Overview of changes in ICD-11: Instytut „She and He" (7.09.2023). ICD-11 – c.d – zaangażuj się i pomóż nam zastopować groźne zmiany! http://onaion.org.pl/2023/09/07/20063/

100 Zucker K., & Duschinsky R. (2015). Dilemmas encountered by the Sexual and Gender Identity Disorders Work Group for DSM-5: an interview with Kenneth J. Zucker. *Psychology & Sexuality* 7, pp.1-11. 10.1080/19419899.2015.1024472.; See also: 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/.

101 A. Steensma Biemond R., de Boer F. et al. (2011) indicate the persistence of gender dysphoria at the level of 2%–27%, B. Wallien (2008) – 27%. The total data from the review of 10 studies indicate a durability level of only 18.26% (calculations in Marianowicz-Szczygieł A. 2021); sources in the following footnotes.

102 Steensma T.D., Biemond R., de Boer F. et al. (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.

103 Wallien B. (2008). *Gender Dysphoria in Children: Causes and Consequences*. PhD-Thesis - Research and graduation internal, Vrije Universiteit Amsterdam. https://research.vu.nl/en/publications/gender-dysphoria-in-children-causes-and-consequences;

104 Cantor J. (11.01.2016). Do trans - kids stay trans- when they grow up? *Sexology Today*. http://www.sexologytoday.org/2016/01/do-trans-kids-stay-trans-when-they-grow_99.html

105 Marianowicz-Szczygieł A. (2021). Zaburzenia tożsamości płciowej u dzieci i młodzieży – ujęcie psychologiczne. Geneza, czynniki ryzyka, rokowania, profilaktyka. *Op.cit*. Tab. 1, p. 107.

106 Drummond K.D., Bradley S.J., Peterson-Badali M. et al. (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.

107 Skordis N., Butler G., de Vries et al. (2019). ESPE and PES international survey of centers and clinicians delivering specialist care for children and adolescents with gender dysphoria. *Hormone Research in Paediatrics*, 90(5), pp. 326–331. https://doi.org/10.1159/000496115; citation based on: Cass H. (2024). The Cass Review. Independent review of gender identity services for children and young people. Final report. *Op.cit*. pp. 88-89.

108 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

may be related to the influences of culture and media[109 110 111 112 113], and the activities of pro-transsexual activists[114]. The phenomenon is sometimes referred to as 'epidemic-like',[115] 'iatrogenic'[116], even a 'peer contagion' or 'social epidemic' [117]. This mandates additional caution.

5. As shown by these 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 and above all, scientifically unconfirmed. It has not passed tests of systematic research reviews, rigorous methodologically meta-analyses and research replicability, and long-term studies are lacking. Hormonal drugs are being used contrary to their previously established indications.

6. Long-acting GnRH analogues used as puberty blockers have been approved in Europe (including Poland) and the USA for the treatment of precocious puberty of central origin (so-called GnRH-dependent), and are also used in the treatment of advanced prostate cancer in men, breast cancer, endometriosis and uterine fibroids in women. However, they have not been approved for use as puberty blockers in the so-called transgender youth in the USA by the FDA[118 119] nor in Europe by the EMA[120], nor in Poland[121]. While when used in children with precocious puberty, the effects of GnRH analogues are reversible (treatment ends at the moment when physiological sexual maturation should occur), but there is no long-term data on their use in youth during transition process (in order to inhibit otherwise normal puberty). However, side effects have been documented, such as reducing bone mineral density and slowing down the growth rate (see next point).

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109 Pang K.C., de Graaf N.M., Chew D. et al. (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

110 Indremo M., Jodensvi A., Arinell H. et al. (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.

111 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.

112 Nagata J.M., Balasubramanian P., Iyra P. et al. (2024). Screen use in transgender and gender-questioning adolescents: Findings from the Adolescent Brain Cognitive Development (ABCD) Study. *Annals of Epidemiology*, 95, s. 6-11. https://www.sciencedirect.com/science/article/pii/S1047279724000632?via%3Dihub

113 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

114 Genspect (18.07.2022). An Open Letter to the American Academy of Pediatrics. *Op.cit*.

115 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

116 Here in reference specifically to social transition: Zucker K. J. (2019). Debate: different strokes for different folks. *Child and Adolescent Mental Health* 25(1), pp. 36-37, https://acamh.onlinelibrary.wiley.com/doi/10.1111/camh.12330

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

118 Salas-Humara C., Sequeira G.M., Rossi W. et al. (2019). Gender affirming medical care of transgender youth. *Current Problems in Pediatric and Adolescent Health Care*, vol. 49, Issue 9, 100683, https://www.sciencedirect.com/science/article/abs/pii/S1538544219301245?via%3Dihub

119 A website where you can check a given medication and its trade names in the USA: https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm; See website of one of these types of popular drugs: https://www.lupron.com/ oraz https://www.accessdata.fda.gov/drugsatfda_docs/nda/pre96/019943_LupronTOC.cfm

120 A similar page for checking medicinal products in Europe on the website of European Medicine Agency (EMA): https://www.ema.europa.eu/en/human-regulatory-overview/marketing-authorisation Compare UE registry: https://ec.europa.eu/health/documents/community-register/html/index_en.htm

121 Website of Polish register (Rejestru Produktów Leczniczych Dopuszczonych do Obrotu na terytorium Rzeczypospolitej Polskiej): https://rejestry.ezdrowie.gov.pl/rpl/search/public

7. Irreversible surgical procedures carried out as part of "medical transition" (gonadectomy, i.e. removal of the testicles or ovaries, hysterectomy, i.e. removal of the uterus) lead to permanent infertility, and the use of hormonal preparations is one cause of infertility (which is considered potentially reversible, but is not guaranteed as the expected outcome in every case) [122] [123] [124] [125] [126] [127]. Hormonal therapies also pose a risk of skeletal disorders, including osteoporosis[128] [129] [130] [131] [132] [133] [134], cardiovascular diseases[135] [136] [137] [138] [139],

122 Hembree W.C., Cohen-Kettenis P.T., Gooren L. et al. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons…*Op. cit*.

123 Coleman E., Radix A.E., Bouman W.P. et al. (2022). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *International Journal of Transgender Health*, 23(S1), S1-S260. https://doi.org/10.1080/26895269.2022.2100644, p.254.

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

125 Cheng P.J., Pastuszak A.W., Myers J.B. et al. (2019). Fertility concerns of the transgender patient. *Transl Androl Urol*. 8 (3), pp.209-218. https://pubmed.ncbi.nlm.nih.gov/31380227/

126 Laidlaw M., Cretella M., Donovan K. (2019). The Right to Best Care for Children Does Not Include the Right to Medical Transition. *The American Journal of Bioethics*, 19(2), pp. 75–77. https://doi.org/10.1080/15265161.2018.1557288

127 A publication providing additional insight into this aspect on the perception of the issue of fertility and permanent infertility by young people identifying as trans: Kerman H.M., Pham A., Crouh J.M. et al. (2021). Gender Diverse Youth on Fertility and Future Family: A Qualitative Analysis. *Journal of Adolescent Health*, Volume 68, Issue 6, pp. 1112 – 1120, https://www.jahonline.org/article/S1054-139X(21)00004-5/abstract

128 Biggs M. (2021). Revisiting the effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria. *Journal of Pediatric Endocrinology and Metabolism* 34 (7), pp. 937-939. https://www.degruyter.com/document/doi/10.1515/jpem-2021-0180/html

129 Stevenson M.O., Tangpricha V. (2019). Osteoporosis and bone health in transgender persons. *Endocrinol Metab Clin North Am*, Jun;48(2), pp.421-427. doi: 10.1016/j.ecl.2019.02.006.

130 Lee J. Y., Finlayson C., Olson-Kennedy J. et al. (2020). Low bone mineral density in early pubertal transgender/gender diverse youth: findings from the trans youth care study. *Journal of the Endocrine Society* 4 *(9)*. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7433770/

131 Vlot M.C., Wiepjes C.M., de Jongh R.T. et al. (2019). Gender-affirming hormone treatment decreases bone turnover in transwomen and older transmen. *J Bone Miner Res*, 34, pp. 1862-1872, https://onlinelibrary.wiley.com/doi/full/10.1002/jbmr.3762?af=R.

132 Pang K.C., Notini L., McDougall R. et al. (2020). Long-term puberty suppression for a nonbinary teenager. *Pediatrics* 145 (2). https://publications.aap.org/pediatrics/article/145/2/e20191606/68237/Long-term-Puberty-Suppression-for-a-Nonbinary?autologincheck=redirected

133 Wierckx K., Mueller S., Weyers S. et al. (2012). Long-term evaluation of cross-sex hormone treatment in transsexual persons. *The Journal of Sexual Medicine* 9 (10), pp. 2641-2651, https://www.sciencedirect.com/science/article/abs/pii/S1743609515337802

134 Delgado-Ruiz R., Swanson P., Romanos G. (2019). Systematic review of the long-term effects of transgender hormone therapy on bone markers and bone mineral density and their potential effects in implant therapy. *Journal of Clinical Medicine* 8 (6), 784. https://doi.org/10.3390/jcm8060784

135 Getahun D., Nash R., Flanders W.D. et al.. (2018). Cross-sex hormones and acute cardiovascular events in transgender persons: a cohort study. *Ann Intern Med*., Aug 21;169(4), pp.205-213. doi: 10.7326/M17-2785.

136 AlzahraniT., NguyenT., Ryan A. et al. (2019). Cardiovascular disease risk factors and myocardial infarction in the transgender population. *Circulation: Cardiovascular Quality and Outcomes* 12 (4):e005597https://www.ahajournals.org/doi/full/10.1161/CIRCOUTCOMES.119.005597

137 Nota N.M., Wiepjes C.M., de Blok C.J.M. et al. (2019). Occurrence of acute cardiovascular events in transgender individuals receiving hormone therapy: results from a large cohort study. *Circulation* 139, pp. 1461-1462 https://www.ahajournals.org/doi/full/10.1161/CIRCULATIONAHA.118.038584

138 Madsen M.C., van Dijk D., Wiepjes C.M et al. (2021). Erythrocytosis in a large cohort of trans men using testosterone: a long-term follow-up study on prevalence, determinants, and exposure years. *The Journal of Clinical Endocrinology & Metabolism* 106 (6), pp.1710–1717. https://academic.oup.com/jcem/article/106/6/1710/6138195

139 Wierckx K., Mueller S., Weyers S. et al. (2012). Long-term evaluation of cross-sex hormone treatment in transsexual persons. *Op.cit.*

some types of cancer [140] [141] [142] [143] [144], liver function disorders, and they increase the risk of its cirrhosis[145] [146], and lead to sexual dysfunctions (reduced libido and even inability to achieve orgasm, painful vaginal atrophy combined with dryness or cracking of its walls). The use of testosterone causes irreversible enlargement of the clitoris, deepening of the voice, androgenetic alopecia, and symptoms of "chemical menopause" in teenagers[147] [148] [149] [150]. Both GnRH analogues and sex steroids (estrogens and testosterone) used during child and adolescent development influence the course of growth[151] [152] [153]. To this directory should be added the risk of complications related to surgical procedures[154] [155] (including urinary or fecal incontinence[156], unsatisfactory appearance and/or function of the sexual organs) and related mental problems. The harmfulness of hormonal

140 Braun H., Nash R., Tangpricha V., Brockman J. et al. (2017). Cancer in transgender people: evidence and methodological considerations. *Epidemiol Rev*, Jan 1;39(1), pp.93-107. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5868281/

141 de Blok C. J. M., Wiepjes C. M., Nota N. M. et al. (2019). Breast cancer risk in transgender people receiving hormone treatment: nationwide cohort study in the Netherlands. *BMJ* 365:l1652 doi:10.1136/bmj.l1652, https://www.bmj.com/content/365/bmj.l1652

142 Sterling J., Garcia M. (2020). Cancer screening in the transgender population: a review of current guidelines, best practices, and a proposed care model. *Translational Andrology And Urology*, 9(6), pp. 2771-2785. https://tau.amegroups.org/article/view/55305/html

143 Leone A.G., Trapani D., Schabath M.B. et al. (2023). Cancer in transgender and gender-diverse persons. *JAMA Oncol*, 9(4), pp.556–563. https://jamanetwork.com/journals/jamaoncology/article-abstract/2801294

144 Loria M., Gilbert D., Tabernacki T. et al. (2024). Incidence of prostate cancer in transgender women in the US: a large database analysis. *Prostate Cancer Prostatic Dis*, on-line DOI: 10.1038/s41391-024-00804-4

145 Hashemi L., Zhang Q., Getahun D. et al. (2021). Longitudinal changes in liver enzyme levels among transgender people receiving gender affirming hormone therapy. *J Sex Med.*, Sep;18(9), pp. 1662-1675. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8444147/

146 Elhence H., Dodge J., Kahn J. et al. (2024). Characteristics and outcomes among us commercially insured transgender adults with cirrhosis: a national cohort study. *The American Journal of Gastroenterology*, June 25, DOI: 10.14309/ajg.0000000000002907 https://journals.lww.com/ajg/abstract/9900/characteristics_and_outcomes_among_u_s_.1209.aspx

147 Coleman E., Radix A.E., Bouman W.P. et al. (2022). Standards of Care for the Health of Transgender and Gender Diverse People *Op.cit.*, p.254.

148 World Professional Association for Transgender Health (2012). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People [7th Version]. *Op cit.*

149 Baldassarre M., Giannone F., Foschini M. et al. (2013). Effects of long-term high dose testosterone administration on vaginal epithelium structure and estrogen receptor-α and -β expression of young women. *International Journal Of Impotence Research*, 25 (5), pp. 172-177. https://go.gale.com/ps/i.do?id=GALE%7CA346526384&sid=googleScholar&v=2.1&it=r&linkaccess=abs&issn=09559930&p=AONE&sw=w&userGroupName=anon%7E5938d206

150 van Trotsenburg M. A. A. (2009). Gynecological aspects of transgender healthcare. *International Journal of Transgenderism*, 11(4), pp. 238–246, doi: 10.1080/15532730903439484. https://www.researchgate.net/publication/247510697_Gynecological_Aspects_of_Transgender_Healthcare

151 Cheung A.S. (2024). Adult height in transgender youth who receive GnRH analogues followed by gender-affirming hormone therapy. *The Journal of Clinical Endocrinology & Metabolism*, dgae397, https://doi.org/10.1210/clinem/dgae397

152 Boogers L.S., Wiepjes Ch.M., Klink D.T. et al. (2022). Transgender girls grow tall: adult height is uneffected by GnRH analogue and estradiol treatment. *The Journal of Clinical Endocrinology & Metabolism*, vol. 107, no 9, September, pp. e3805–e3815, https://doi.org/10.1210/clinem/dgac349

153 Roberts S.A., Carswell J.M. (2021). Growth, growth potential, and influences on adult height in the transgender and gender-diverse population. *Andrology*, Nov;9(6), pp. 1679-1688. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9135059/

154 Dreher P.C., Edwards D., Hager S. et al. (2018). Complications of the neovagina in male-to-female transgender surgery: A systematic review and meta-analysis with discussion of management. *Clin Anat*. 31 (2), pp.191-199. https://pubmed.ncbi.nlm.nih.gov/29057562/

155 Manrique O., Adabi K., Martinez-Jorge J. et al. (2018). Complications and patient-reported outcomes in male-to-female vaginoplasty—where we are today. *Annals of Plastic Surgery* 80 (6), pp. 684-691 https://pubmed.ncbi.nlm.nih.gov/29489533/

156 See the summary of research on the website: https://statsforgender.org/medical-transition/

preparations may increase with the time of their use[157] [158], and long-term data coming directly from medical registers confirm a higher number of deaths among transgender people compared to the general population[159] [160]; the scale of several years[161] is not a sufficient indicator here. The risk of individual complications and chronic diseases may vary depending on gender and hormonal therapies used.

8. The impact of hormonal transition, especially on brain development and intellectual processes in children and adolescents[162] [163], is not fully known, and current research confirms decreased cognitive functions[164] or gender-atypical brain development[165]. Simply "there is some evidence of a harmful effect of blocking puberty on the decline of children's IQ [intelligence quotient]"[166], but the mere completion of a given stage of education is not a sufficient indicator here[167]. There are also no estimated long-term effects. Due to ethical and methodological challenges for research in this field, disturbing data from animal tests should also be taken into account[168] [169] [170]. Sex hormones affect the sexual differentiation of the brain and its attainment of full maturity as the 'plasticity' of brain neurons continues at least until the end of sexual maturation[171] [172]. 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" but an interference in the development of the still-

157 See Getahun D., Nash R., Flanders W.D. et al. (2018). Cross-sex hormones and acute cardiovascular events in transgender persons: a cohort study. *Op. cit.*

158 Vlot M.C., Wiepjes C.M., de Jongh R.T. et al. (2019). Gender-affirming hormone treatment decreases bone turnover in transwomen and older transmen. *Op.cit.*

159 de Blok C.J.M., Wiepjes C.M., van Velzen D.M. et al. (2021). Mortality trends over five decades in adult transgender people receiving hormone treatment: a report from the Amsterdam cohort of gender dysphoria. *The Lancet Diabetes & Endocrinology* 9, pp. 663-670. https://www.thelancet.com/journals/landia/article/PIIS2213-8587(21)00185-6/abstract

160 Dhejne C., Lichtenstein P., Boman M. et al. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery…*Op.cit*.

161 Elhence H., Dodge J., Kahn J. et al. (2024). Characteristics and outcomes among us commercially insured transgender adults with cirrhosis: a national cohort study. *Op.cit.*

162 Cass H. (04.2024). The Cass Review. Independent review of gender identity services for children and young people. Final report. *Op. cit.*, p.32, point 82.

163 Hembree W.C., Cohen-Kettenis P.T., Gooren L. et al. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: an endocrine society clinical practice guideline. *Op. cit*. pp. 3882-3883.

164 Baxendalle S. (2024). The impact of suppressing puberty on neuropsychological function: A review**.** *Acta Paediatrica* 113, pp. 1156–1167, DOI: 10.1111/apa.17150.

165 Staphorsius A.S., Kreukels B.P., Schagen S.E. et al. (2015). Puberty suppression and executive functioning: An fMRI-study in adolescents with gender dysphoria. Psychoneuroendocrinology, Jun;56, pp.190-199. doi:10.1016/j.psyneuen.2015.03.007

166 Baxendalle S. (2024). The impact of suppressing puberty on neuropsychological function: A review *Op.cit*., p.1163.

167 Arnoldussen M., Hooijman EC., Kreukels BP. et al. (2022). Association between pre-treatment IQ and educational achievement after gender-affirming treatment including puberty suppression in transgender adolescents. *Clinical Child Psychology and Psychiatry*, 27(4), pp.1069-1076. doi:10.1177/13591045221091652

168 Gómez Á., Cerdán S., Pérez-Laso C. et al. (2020). Effects of adult male rat feminization treatments on brain morphology and metabolomic profile. *Hormones and Behavior*, *125*, 104839 ; https://www.sciencedirect.com/science/article/abs/pii/S0018506X20301653

169 Oliveira G.F., Nguyen A.T., Carreras-Simons L. et al. (2024). Puberty blocker, leuprolide, reduces sex differences in rough-and-tumble play and anxiety-like behavior in juvenile rats. *Endocrinology*, Mar 29;165(5):bqae046. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC11033216/

170 Hough D., Bellingham M., Haraldsen I. R. H. i in. (2017). Spatial memory is impaired by peripubertal GnRH agonist treatment and testosterone replacement in sheep. Psychoneuroendocrinology, Jan; 75, s. 173–182. doi: 10.1016/j.psyneuen.2016.10.016.

171 Trova S., Bovetti S., Bonzano S. et al. (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

172 Cass H. (04.2024). The Cass Review. Independent review of gender identity services for children and young people. Final report. *Op. cit.*, pp.103-104.

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 risky behavior – please see chapter IV, paragraph 3)[173 174 175]. 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. Society should strive to prevent children from making such risky, impulsive, far-reaching, and irreversible decisions. Currently, professional positions with a cautious tone are increasingly dominant.

9. So-called social transition, especially in social (i.e. 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 other people around the child (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.). We formulate our position on this issue on the basis of comprehensive knowledge about the broad etiology of gender identity disorders and clinical and developmental psychology, ethical, historical and legal considerations, and especially on the basis of the very high impermanence of gender dysphoria, which never has a predictable trajectory in a given child and also presents a high risk of induction and enforcement in children. The area of social transition in children and adolescents has not been sufficiently explored scientifically[176], but the existing data call for caution[177 178 179 180 181]. In the vast majority of cases where a decision is made to use puberty blockers, the child goes on to take hormones of the opposite sex, i.e. 98%-100%[182 183 184]. In the area of social transition, there may be a similar psychological inclination towards medical

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173 Luna B. et al. (2001). Maturation of widely distributed brain function subserves cognitive development, *NeuroImage* 13 (5), pp. 786–93, https://doi.org/10.1006/nimg.2000.0743.

174 Giedd J.N. (19 May 2015). The amazing teen brain. *Scientific American* 312 (6), pp.32–37, https://doi.org/10.1038/scientificamerican0615-32.

175 Arain M., Haque M., Johal L. et al. (2013). Maturation of the adolescent brain. *Neuropsychiatr Dis Treat* 9, pp. 449-61. doi: 10.2147/NDT.S39776.

176 „However, none of the WPATH 8 statements in favour of social transition in childhood are supported by the findings of the University of York's systematic review (Hall et al: Social Transition). Given the weakness of the research in this area there remain many unknowns about the impact of social transition. In particular, it is unclear whether it alters the trajectory of gender development, and what short- and longer-term impact this may have on mental health". Cass H. (04.2024). The Cass Review. Independent review of gender identity services for children and young people. Final report. *Op. cit*. p. 163

177 Zucker K. J. (2019). Debate: Different strokes for different folks. *Child and Adolescent Mental Health* 25(1), pp. 36-37, https://acamh.onlinelibrary.wiley.com/doi/10.1111/camh.12330

178 de Vries A. L., 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. https://doi.org/10.1080/00918369.2012.653300

179 Steensma T.D., McGuire J.K., Kreukels B.P. et al. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. *J Am Acad Child Adolesc Psychiatry*. 52 (6), pp. 582-590. https://pubmed.ncbi.nlm.nih.gov/23702447/

180 Cass H. (04.2024). *The Cass Review. Independent review of gender identity services for children and young people*. Final report. *Op.cit*.p.31.

181 Olson K., Durwood L., Horton R. et al. (2022). Gender identity 5 years after social transition. *Pediatrics*, special article. https://pubmed.ncbi.nlm.nih.gov/35505568/

182 Carmichael P., Butler G., Masic U. et al. (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. *Plos One* 16 (2). https://doi.org/10.1371/journal.pone.0243894

183 Wiepjes C.M., Nota N.M., de Blok C.J.M. et al. (2018). The Amsterdam cohort of gender dysphoria study (1972-2015): Trends in Prevalence, Treatment, and Regrets. *Journal of Sexual Medicine* 15 (4). https://doi.org/10.1016/j.jsxm.2018.01.016 p.4.

184 de Vries A.L.C., Steensma T.D., Doreleijers T.A. et al. (2011). Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. *J Sex Med 8* (8), pp.2276-83. https://pubmed.ncbi.nlm.nih.gov/20646177/

transition, i.e. social transition would facilitate the next steps, i.e. taking puberty blockers and other medical treatments. This limits natural development processes.

10. 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, ADHD, depression, suicidal tendencies, disorders in self-image, body perception, body dysmorphic disorder - BDD, and self-worth) [185] [186] [187] [188] [189] [190] [191], and specific family difficulties have been seen to be associated [192] [193] [194] [195] [196] [197] [198] [199].

11. Symptoms of gender identity disorders may thus be only symptoms caused by other factors. Therefore, a young person's problems related to gender identity should not be treated in isolation or solely from a social perspective.

12. 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

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185 Kaltiala-Heino R., Sumia M., Työläjärvi M. et al. (2015). Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. *Child and Adolescent Psychiatry and Mental Health* (2015) 9:9. DOI:10.1186/s13034-015-0042-y

186 Bechard M., VanderLaan D.P., Wood H. et al. (2017). Psychosocial and Psychological Vulnerability in Adolescents with Gender Dysphoria: a "proof of Principle" Study, *J Sex and Marital Therapy* 43, pp. 678-688. DOI: 10.1080/0092623X.2016.1232325

187 Heylens G., Elaut E., Kreukels B.P.C., et al. (2014). Psychiatric characteristics in transsexual individuals: multicentre study in four European countries. *The British Journal of Psychiatry,* Feb, 204 (2), pp. 151-156; DOI: 10.1192/bjp.bp.112.121954.

188 Becerra-Culqui T.A., Liu Y., Nash R., et al. (2018). Mental health of transgender and gender nonconforming youth compared with their peers. *Pediatrics* 141(5):e20173845. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5914494/

189 Kozlowska K., McClure G., Chudleigh C. et al. (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; See: Kozlowska, K., Chudleigh, C., McClure, G., Maguire, A.M., & Ambler, G.R. (2021). Attachment patterns in children and adolescents with gender dysphoria. Frontiers in Psychology, 11, Article 582688. https://pubmed.ncbi.nlm.nih.gov/33510668/. https://doi.org/10.3389/fpsyg.2020.582688

190 Littman L. (16.04.2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria, *Op cit.*

191 Russell D.H., Hoq M., Coghill D. et al. (2022). Prevalence of mental health problems in transgender children aged 9 to 10 years in the US, 2018. *JAMA Netw Open*, 5(7):e2223389. doi:10.1001/jamanetworkopen.2022.23389

192 Cass H. (04.2024). The Cass Review. Independent review of gender identity services for children and young people. Final report. *Op. cit.*, p. 94, 5.50: „over a quarter of all referrals had spent some time in care and nearly half of all referrals had experienced living with only one parent. It showed that 42% of the children covered by the audit experienced the loss of one or both parents, mainly through separation; 38% had family physical health problems; and 38% had family mental health problems. Physical abuse was documented in 15% of cases."

193 Schneeberger A.R., Dietl M.F., Muenzenmaier K.H. et al. (2014). Stressful childhood experiences and health outcomes in sexual minority populations: A systematic review. *Social Psychiatry and Psychiatric Epidemiology*, 49, s.1427-1445. https://doi.org/10.1007/s00127-014-0854-8

194 Baams L. (2018). Disparities for LGBTQ and gender nonconforming adolescents. *Pediatrics*, 141(5), e20173004. https://doi.org/10.1542/peds.2017-3004

195 Kozlowska K., McClure G., Chudleigh C., et al. (2021). Australian children and adolescents with gender dysphoria: clinical presentations and challenges experienced by a multidisciplinary team and gender service. *Op cit.*

196 Kozlowska K., Chudleigh C., McClure G. et al. (2021). Attachment patterns in children and adolescents with gender dysphoria. *Frontiers in Psychology*, 11, Article 582688. https://pubmed.ncbi.nlm.nih.gov/33510668/. https://doi.org/10.3389/fpsyg.2020.582688

197 Hisle-Gorman E., Schvey N.A., Adirim T.A. et al. (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/

198 See: Becerra-Culqui T.A., Liu Y., Nash R., Cromwell L. et al. (2018). Mental health of transgender and gender nonconforming youth compared with their peers. *Op cit.*

199 See: Glintborg D., Mřller J.J.K., Rubin K.H. et al. (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

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.

13. Any symptoms of depression or suicidal tendencies should not be underestimated and should be treated with great care, using the prescribed procedures. You should also be aware of declared suicidal tendencies in the case of children and youth with GID, especially those under the influence of activists, they may only be a form of emotional blackmail or the result of the Werther effect[200]. There has also been described outright indoctrination and coaching of youth (or parents) to deceitfully persuade a parent/ legal guardian (or a given facility) to consent to transition[201 202 203]. There is no scientific data indicating automatic suicidality in cases of gender identity disorders, or even suggesting that transition would supposedly protect against suicide[204 205 206 207 208 209 210 211], especially since adolescence itself is generally characterized by an increased risk of suicidal tendencies. The increased risk of suicidal tendencies in this group may result from frequent co-occurring disorders, such as depression, anxiety disorders and a generally risky lifestyle, and therefore may come from other sources[212 213]. For example, the risk of self-harm and suicide attempts in the case of body dysmorphic disorder

200 Acosta F. J., Rodríguez C. J., Cejas M. R. et al. (2020). Suicide coverage in the digital press media: adherence to world health organization guidelines and effectiveness of different interventions aimed at media professionals. *Health Communication* 35 (13), pp. 1623–1632 https://www.tandfonline.com/doi/full/10.1080/10410236.2019.1654176

201 Horan N. (2019). Patients "coached" to fast-track sex change treatment'," *Independent.ie*, Sept/ 29, https://www.independent.ie/irish-news/health/patients-coached-to-fast-track-sex-change-treatment-38543409.html

202 Keenan J. (1.04.2019). 'Doctor' advises threatening suicide to get transgender treatments for kids. *The Federalist.* https://thefederalist.com/2019/04/01/doctor-advises-threatening-suicide-get-transgender-treatments-kids/

203 Shrier A. (2023). *Nieodwracalna krzywda*. Kraków: Dystrybucja AA/ *Eng. Irreversible Damage.*

204 „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. *Op cit.*, chapter7, p.26

205 Cass H. (04.2024). *The Cass Review. Independent review of gender identity services for children and young people*. Final report. *Op.cit.*, p.33: "It has been suggested that hormone treatment reduces the elevated risk of death by suicide in this population, but the evidence found did not support this conclusion".

206 Asscheman H., Giltay E. J., Megens J. A. J. et al. (2011). A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. *European Journal of Endocrinology* 164 (4), pp. 635-642. https://pubmed.ncbi.nlm.nih.gov/21266549/

207 Dhejne C., Lichtenstein P., Boman M. et al. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *Op.cit.*

208 Biggs M. (2022). Suicide by clinic-referred transgender adolescents in the United Kingdom. *Archives of Sexual Behavior*, 51, s.685-690. https://doi.org/10.1007/s10508-022-02287-7

209 Swedish National Board of Health and Welfare (2020). Utvecklingen av diagnosen könsdysfori: Förekomst, samtidiga psykiatriska diagnoser och dödlighet i suicid. Socialstyrelsen, pp.10. https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2020-2-6600.pdf

210 Kalin N.H. (2020). Reassessing mental health treatment utilization reduction in transgender individuals after gender-affirming surgeries: a comment by the editor on the process (letter). *Am J Psychiatry* 177 (8), pp. 764 -765 https://doi.org/10.1176/appi.ajp.2020.20060803; with reference to: Bränström R, Pachankis J.E. (2020). Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: a total population study. *Am J Psychiatry* 177, pp.727–734. https://doi.org/10.1176/appi.ajp.2019.19010080

211 Bailey J.M., Blanchard R. (8.09.2017). Suicide or transition: The only options for gender dysphoric kids? 4thwave-now.com. https://4thwavenow.com/2017/09/08/suicide-or-transition-the-only-options-for-gender-dysphoric-kids/

212 Hisle-Gorman E. Schvey N.A., Adirim T.A., et al. (2021). Mental healthcare utilization of transgender youth before and after affirming treatment. *The Journal of Sexual Medicine*, Vol. 18, Issue 8, August, pp.1444–1454, https://doi.org/10.1016/j.jsxm.2021.05.014

213 Eisenberg M.E., Gower A.L., McMorris B.J. et al. (2017). Risk and protective factors in the lives of transgender/gender non-conforming adolescents. *Journal of Adolescent Health*, Oct; 61(4), pp. 521–526. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5626022/

(BDD)[214], which is quite common in this group[215], is as high as 46.3%[216].

14. 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)[217 218] or wrapping and hiding (tacking) male genitalia[219 220].

214 Body Dysmorphic Disorder – i.e. a strong, even obsessive belief in the unsightly structure of one's body or some part of it.

215 Cass H. (04.2024). The Cass Review. Independent review of gender identity services for children and young people. Final report. *Op.cit.*, p.92.

216 Krebs G., Clark B., Ford T. et al. (2024). Epidemiology of body dysmorphic disorder and appearance preoccupation in youth: prevalence, comorbidity and psychosocial impairment. *Journal of the American Academy of Child & Adolescent Psychiatry*. DOI:10.31234/osf.io/zmd2h

217 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

218 Poteat T., Malik M., Cooney E. (2018). Understanding the health effects of binding and tucking for gender affirmation. *Journal of Clinical and Translational Science* 2 (Suppl 1), 76. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6798434/

219 Poteat T., Malik M., Cooney E. (2018). Understanding the health effects of binding and tucking…*Op.cit.*

220 Debarbo C.J.M. (2020). Rare cause of testicular torsion in a transwoman: A case report. *Urology Case Reports* 33, 101422. https://doi.org/10.1016/j.eucr.2020.101422.

CHAPTER 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 and other risks).

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). An informed consent for transition in the case of children and adolescents is a fiction[221] [222] [223] [224] (please see chapter III.8 on the developing adolescent brain).

4. Every patient should have the right to psychotherapy as a primary form of treatment, which 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 of gender dysphoria, and the mostly spontaneous resolution of transsexual feelings are sufficient reasons not to support so-called social transition (please see chapter III.9) 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 inappropriate and unlawful[225]. We also propose that educational institutions that enable their students to make social transitions on school premises should be required to prepare reports on the social impact and risks of such steps, citing scientific research.

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

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221 National Institute of Mental Health (2001). Teenage brain: a work in progress. *NIH Publication* No. 01-4929. https://www.psychceu.com/Brain_Basics/teenbrain.pdf

222 Latham A. (2022). Puberty blockers for children: can they consent? *The New Bioethics*, 28:3, pp. 268-291, DOI: 10.1080/20502877.2022.2088048

223 Steinberg L. (2008). A social neuroscience perspective on adolescent risk-taking. *Dev Rev*. Mar;28(1), pp.78-106. doi: 10.1016/j.dr.2007.08.002.

224 Arain M., Haque M., Johal L. et al. (2013). Maturation of the adolescent brain. *Neuropsychiatr Dis Treat*., 9, pp. 449-461 https://doi.org/10.2147/NDT.S39776

225 Examples of some guides: https://genspect.org/resources/guidance/ ; Please see also: Puzio M. (2024). Gdy Kasia twierdzi, że jest Tomkiem. Aspekty prawne genderowych sporów o zaimki w polskiej szkole. Poradnik dla nauczycieli. Ordo Iuris. https://ordoiuris.pl/sites/default/files/inline-files/Poradnik_zaimkowy_0.pdf

of neighbour" is a universal, sufficient, and well-known concept anchored in Judeo-Christian tradition[226] and history of European civilization - empathetic and merciful, but also courageous love capable of setting boundaries for the good of the individual when necessary. So we do not support 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[227], 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 developmental psychology and other field indicates, that so-called gender-neutral upbringing prevents the development of a gender identity consistent with one's sex (in terms of biology), as previously discussed. 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 (see II.19). Individuals undergoing detransition should be guaranteed care from endocrinologists and psychotherapists, as well as legal support in returning to the previous state before transition (although some consequences of earlier medical procedures may be irreversible). There is "life after detransition," and there is hope for such individuals.

9. We also oppose all attempts to isolate parents from their children with gender identity disorders or to limit parental authority in this area, including those attempts demonstrated in WPATH standards (SOC 7 and SOC 8)[228] – standards that ignore existing scientific evidence and rely on scientific evidence that is low-quality, unreliable, at very high risk of bias, and does not employ the scientific principle of cause-and-effect reasoning[229] [230] [231] [232]. 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: a prohibition against social, hormonal, surgical, and legal transition, especially irreversible steps, a prohibition against causing infertility or permanent body disfigurements[233], particularly without the consent of parents/legal guardians.

It should be emphasized that **the legal age limit** of 18 years does not completely coincide with

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226 Haynes L. (16.09.2019). Are religious Californians really harming the mental health of people who identify as LGBTQ? https://www.thepublicdiscourse.com/2019/09/56790/

227 See: Kosciw J. G., Greytak E. A., Zongrone A. D. et al. (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

228 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).

229 Dahlen S., Connolly D., Arif I. et al. (2021). International clinical practice guidelines for gender minority/trans people: systematic review and quality assessment. *BMJ Open* 11:e048943. doi: 10.1136/bmjopen-2021-048943

230 Hughs M. (2024). The WPATH Files. Pseudoscientific surgical and hormonal experiments on children, adolescents, and vulnerable adults. *Environmental Progress. Op.cit.*

231 Hruz P.W. (2020). Deficiencies in scientific evidence for medical management of gender dysphoria. *The Linacre Quarterly*, Vol. 87(1), pp. 34-42, https://journals.sagepub.com/doi/10.1177/0024363919873762 p.37

232 (2022). Statement of Removal, International Journal of Transgender Health, 23:sup1, S259-S259, DOI: 10.1080/26895269.2022.2125695, WPATH-8 publication note and we read here: „This correction notice has been removed as it referred to a previous version of the article, which was published in error".

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

the psychological limit of mental or social maturity. There are also large individual differences here. This is of great importance from the perspective of considerations regarding the age of admissibility of medical transition under the law. If anything, the age that is more justified from the point of view of psychology, when it comes to the legal limit of the minimum admissibility of transition, is the age of 25-26[234]. An important argument in this context is the fact that with age, most children and adolescents "grow out" of this type of problem (see Chapter III, paragraph 3) and that decisions are made that may permanently affect fertility. 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 sex in biological terms 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 sex in biological terms, and treats gender identity disorders as a manifestation of "sexual health")[235].

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234 We're standing here on the ground of general knowledge in the field of neurobiology and developmental psychology (brain and personality development - sources: Trova S., Bovetti S., Bonzano S. et al. .2021; Luna B. Thulbron K.R., Munoz D.P. et al. 2001; Jay N. Giedd 2015, Arain M., Hague M., Johal L. et al. 2013 – see chapter III. 8; and knowledge about the risks of medical effects – see chapter III.6) and detailed knowledge covering issues related to the development of gender identity disorders. 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 (in the UKOM report - in chapter 8, p.33, it is given as an argument against the use of early transition in children that decisions are made regarding fertility, and "the threshold for consent to sterilization in Norway is 25 years"; Cass Review: the limit is approx. 25 years as the limit for the development of the frontal lobes, and therefore for making complex decisions, critical thinking, planning, setting priorities, refraining from impulses - Cass H. 2024 Op. cit, pp. 102-103, although the age limit was basically set at 18 limit of medical interventions and limited access to puberty blockers only within a clinical trial from 16 years, thus committing scientific inconsistency); 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. Op.cit*. Cass H. (04.2024). The Cass Review. Independent review of gender identity services for children and young people. Final report. *Op. cit.*

235 Internet ICD-11 Browser: https://icd.who.int/browse/2024-01/mms/en#577470983 See: Institute „She and He" (7.09.2023). ICD-11 – c.d. – Zaangażuj się i pomóż nam zastopować groźne zmiany! http://onaion.org.pl/2023/09/07/20063/

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 undergraduate 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-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[236].

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

CHAPTER 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[237] 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.

PRELIMINARY DIAGNOSIS

In the case of suspected gender identity disorders (referred to as GID), 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)[238]:

A. a strong desire to be of the opposite sex,

B. non-acceptance of one's body, including sexual organs and signs of puberty,

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,

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237 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 (See: Cass H. 2024. The Cass Review. Independent review of gender identity services for children and young people. Final report. *Op.cit.*, p. 203). 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.

238 As already announced, we use an objective approach, based on biological reality, i.e. we oppose the use of the criterion of distress, as in subjective discomfort as an exclusive criterion – 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" (GID).

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[239], 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.

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 (GID) 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 stage of puberty 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 - if needed. It is also essential to determine the state of patient's knowledge and attitude toward puberty and its symptoms. If necessary, the specialist provides essential clarifications, especially in the case of an anxious attitude. The way of going through puberty has a diagnostic character and probably affects whether gender dysphoria subsides or not[240]. It's also necessary to assess health status for chronic diseases and somatic disorders, especially

239 Time criteria based on the DSM index.

240 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*, vol. 16 (4), pp. 499-516. https://journals.sagepub.com/doi/abs/10.1177/1359104510378303

those related to sex, alternatively to make sure about the proper development of the sexual organs (to check for possible congenital defects), to perform basic laboratory tests, among others 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 cancers and liver diseases. These activities are performed by the primary health care doctor.

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. Due to organizational issues, such as long waiting times for the consultations of specialists, this should not delay the psychological diagnosis.

— Somatic Differential Diagnosis (including endocrinological and genetic)

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

B. 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 puberty, chronic diseases, and medications usage (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: measurement of concentrations 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-OH-progesterone, testosterone, ACTH, cortisol, PRA (plasma renin activity), and aldosterone in the serum, and possibly a test with ACTH,

C. genetic diagnosis: 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).

If such a panel of tests does not reveal any abnormalities, we continue diagnostics in the area of mental health. In the case of abnormalities - further diagnostics should be conducted according to medical standards referring to specific situations, i.e., suspected disease entities (e.g., sex differentiation disorders, late-onset congenital adrenal hyperplasia, hormonally active tumours, etc.). The mentioned disorders may also constitute the somatic background of gender identity disorders.

— Psychiatric and Psychological Differential Diagnosis

It's necessary to diagnose and/or exclude:

A. psychoses (e.g., delusions of sex change[241]),

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)

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 sex in biological terms (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.

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241 "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

COMPREHENSIVE PSYCHOLOGICAL ASSESSMENT

The comprehensive psychological assessment pertains to areas associated with the potential and known psychological origins of gender dysphoria (often overlooked)[242] 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. 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)[243]: at least one 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. 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. 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 (as for example BDD),

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,

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242 Overview of research on genesis - see chapter III.1

243 A detailed description of an exemplary diagnostic and therapeutic procedure is described in the work: A. Marianowicz-Szczygieł. *A review of 24 professional standards, positions and models of helping children and young people with gender identity problems. Conclusions for the Polish model. In Press*, following Zucker J.K. Wood H., Singh D. et al. (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 J.K. Wood H., Singh D. et al. (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

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),

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 (GID) based on fears related to puberty and the possibility of unaccepted homosexual tendencies and "escape" from them in the desire to neutralize sex in biological terms (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, ADHD,

T. depression/suicidality/self-harm,

U. anxiety disorders,

V. obsessive-compulsive disorders,

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[244]. 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 GID in the child.

In cases where a diagnosis of Gender Identity Disorder (GID), 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 passive/mixed approach (somewhere in between the gender-affirming and the comprehensive approaches), and the pathway we can call comprehensive (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[245]. It is important to note the lack of reliable scientific evidence and lack of professional consensus for medical "affirmation"[246] [247] and to caution against the unjustified promotion in the public space of the gender-affirming 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**[248] 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.). This proposal should be discussed between the professional - the patient/client and his or her relatives and, if necessary, modified until acceptance is obtained. If possible, the entire family system

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244 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.

245 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. et al. (2017). Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society...*Op. cit.*; and: Coleman E., Radix A. E., Bouman W.P. et al. (2022). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *Op. cit.*, pp. 119 and 254-257; Hansen M.V. , Giraldi A., Main K.M., et al. (3.07.2023). Ugeskrift for Læger . Sundhedsfaglige tilbud til børn og unge med kønsubehag. *Op. cit.*

246 Dahlen S., Connolly D., Arif I. et al. (2021). International clinical practice guidelines for gender minority/trans people: systematic review and quality assessment. *BMJ Open* 11:e048943. doi: 10.1136/bmjopen-2021-048943

247 Block J. (2023). Gender dysphoria in young people is rising—and so is professional Disagreement. *BMJ* 380, p. 382 http://dx.doi.org/10.1136/bmj.p382

248 Individualized forms of professional help also recommends Cass H. (04.2024). The Cass Review. Independent review of gender identity services for children and young people. Final report. *Op. cit.*, p.143, pp.146-147.

should be included in the assistance[249]. We recommend that the proposed therapy be comprehensive and also directed at other accompanying problems, including coordination taking into account medical problems.

PSYCHOTHERAPY

In therapy, the primary focus should be on addressing existing mental health issues and family system disorders. Therefore, psychotherapy[250] should be at least the first option[251] of choice and preceded by signing a transparent psychotherapy contract. 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"[252]. Psychotherapy can help 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[253]. 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.

249 Source as above, Recommendation 3, p.157.

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

251 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.

252 Marianowicz-Szczygieł A., A review of 24 professional standards, positions and models of helping children and young people with gender identity problems. Conclusions for the Polish model. In press, 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 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.'

253 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

In addition to deepening diagnostic questions, we recommend a detailed examination of the possibility of various psychological mechanisms:

A. the possibility of symptoms of gender identity disorders as reactive symptoms of specific, strong, traumatic experiences,

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,

E. the effect of disturbed family dynamics and structure.

Special attention should be paid to:

Ref. **A.** the possible reactivity of specific, strong, traumatic experiences: 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,

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); syndrome of lack of sense of belonging (social identity crisis, lack of roots), overuse of new technologies at the expense of the ability to establish social relationships.

Ref. **E.** possible influences of disturbed family structure and dynamics: physical or emotional absence of one of the parents, disturbed communication, disturbed parental attitudes and mutual relationships, repetitive destructive generational patterns of behavior, etc. (see stages of diagnosis of the family system); in justified cases, marital therapy aimed at improving the relationship between parents or systemic therapy for the entire family would be recommended; Improving the parents' relationship helps the child gain space to connect and develop relationships with the same-sex parent, same-sex relatives, and

same-sex peers[254].

We recommend a therapeutic session with the child and parents approximately every 4 meetings, and a separate meeting with the parents themselves approximately every 8 sessions. Cooperation with parents should be an integral and important part of the therapeutic process. During psychotherapy, one should remember about the high individual variability of the picture and course of GID as well as the variability influenced by co-occurring disorders (a different picture of GID combined with obsessive-compulsive disorder or ADHD).

If necessary, a special task for a psychiatrist in an interdisciplinary team is ongoing pharmacological support.

A specific task for the psychiatrist in the interdisciplinary team is to provide ongoing psychopharmacological 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 (GID) 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 subcultures or sects[255], have been described in youth groups 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[256]. It is important that the above change in environment is appealing to the adolescent[257]. However, in every case, a parent should monitor the adolescent's online activity (without violating privacy) and establish appropriate boundaries and limits[258].

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.

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

254 Kosky R.J. (1987). Gender-disordered children: does inpatient treatment help? *Medical Journal of Australia, 146*, pp.565-569. https://pubmed.ncbi.nlm.nih.gov/3614045/ Lim; M.H. & Bottomley V.A (1983). Combined approach to the treatment of effeminate behaviour in a boy: A case study. *Journal of Child Psychology and Psychiatry, 24*, pp.469-479. https://pubmed.ncbi.nlm.nih.gov/6874790/; Zucker K. J. (1985). Chapter 4: Cross-Gender-Identified Children. in: Steiner B.W. [ed.]. Gender *Dysphoria: Development, Research, Management*, pp. 75-174. New York: Plenum Press. https://link.springer.com/book/10.1007/978-1-4684-4784-2

255 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.'

256 *Ibidem*, p.99.

257 *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.

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

is BMI control and targeted prevention of both underweight and obesity)[259].

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, comprehensive, 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 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.

Association of Christian Psychologists in Poland, Warsaw, October 2024

www.spch.pl

259 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: [.1.] Moser C.N., Fornander M.J., Roberts C.M. et al. (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. [2.] Fornander M.J., Roberts T., Egan A.M. et al. (2022). Weight status, medication use, and recreational activities of treatment-naïve transgender youth. *Child Obes*, Jun, 18(4), pp.228-236. doi: 10.1089/chi.2021.0155.

ANNEX – REFERENCES TO THE AGREE II EVALUATION SYSTEM

Presentation of the document in terms of compliance with the guidelines of the AGREE II evaluation system.

The internationally recognized AGREE II system with over 20 years of history[260] is used to evaluate the clinically and methodologically rigorous process of creating professional guidelines and standards of clinical assistance and the scientific research. Six areas are assessed:

Domain 1. Scope and purpose

Domain 2. Stakeholder involvement

Domain 3. Rigour of development

Domain 4. Clarity of presentation

Domain 5. Applicability

Domain 6. Editorial independence

These data, in relation to these standards, are provided below.

Domain 1. Scope and purpose

The purpose of this document is to provide tangible and practical help for clinicians who work with children and adolescents reporting problems with gender identification, for their families and their immediate environment. The document provides scientific knowledge, proposes detailed guidelines for differential diagnosis and psychological diagnosis, and specific guidelines for psychotherapy and medical assistance. It also formulates conclusions for public policies. Therefore, it contains answers to basic questions: how gender identity disorders arise, how homogeneous the clinical picture is in the population of these disorders, what constitutes a correct diagnosis and professional, individualized help.

There is a great diversity of positions around the world. In our opinion, it results not so much from the lack of scientific evidence, although this is a relatively new area where knowledge is and should be constantly supplemented, but from the lack of interdisciplinary integration of this knowledge. Therefore, a special challenge while working on the document, there was an interdisciplinary combination of perspectives while avoiding the medicalization of problems with a predominantly psychological origin. This challenge means that many international guidelines, although based on scientific evidence, make methodological errors and either ignore available psychological knowledge or remain ambiguous, transferring the responsibility for the decision on the mode of therapy to specific clinicians or families, although, of course, an individualized approach is always highly advisable. These standards are therefore of a psychological and medical nature, unlike the numerically dominant medical or medical-psychological standards.

260 AGREE Next Steps Consortium (2017). The AGREE II Instrument [on-line]. https://www.agreetrust.org/wp-content/uploads/2017/12/AGREE-II-Users-Manual-and-23-item-Instrument-2009-Update-2017.pdf

Domain 2. Stakeholder involvement when creating the SPCh Standards

First (autumn 2023), a working version was created and subjected to publicly available public consultations. The document (in Polish and English versions) was available on the SPCh website in the SPCh Team for Sex and Sexuality tab[261]. Anyone could send comments to the document, as indicated in the appropriate entry on the title page ("document for public consultation"). The document was also widely disseminated in the SPCh media, as well as by and among several hundred SPCh members, propagated in the media and reached professionals through various channels. Over the course of a year (until fall 2024, when this revised version was created), several comments were received and have been incorporated into the current version. We now also encourage you to submit professional opinions that will help improve the document in the future.

An interdisciplinary team of specialists in various specialties, both SPCh members and outside the organization, was gathered to create the document. The team consisted of: psychologists, psychotherapists for children and adolescents, family and addiction therapists, sexologists and doctors (with specialties: family medicine, psychiatry, pediatric endocrinology, gynecology and obstetrics), both clinicians and researchers. Most of the people working on the development of The Standards used its own clinical experience in the area of gender identity disorders. The form of consultation included e-mails to experts from abroad asking for the evaluation of the Standards. As a result, 8 opinions were published at the beginning of the document. Professionals also began to use the first version of the document in their clinical work usually with positive or very positive feedback.

The recipients of the document are: psychologists (including school psychologists), psychotherapists, doctors of various specialties, teachers, educators, pastors and leaders of youth groups, parents, lawyers, creators of public policies and researchers from various fields.

Domain 3. Rigour of development of the document

The process of creating the document consisted of several stages. The outline of the document was discussed in several online meetings of the working team and subjected to evaluation and feedback in e-mails. The final form was voted by the SPCh Team for Gender and Sexuality and presented to the SPCh Main Board and approved here after adding the last, minor comments. The main coordinator, who presented the first, initial outline of the document during work on both editions, collected comments and made corrections, was psychologist Agnieszka Marianowicz-Szczygiel. However, the quality of the document depends on the hard work of many experts and a tedious, multi-stage verification of the document's content. In the current, second version of the document, we have tried to take into account the conclusions and comments that we received after the publication of the first version in autumn 2023, to clarify certain concepts, and, above all, to update and significantly enrich the bibliography, especially in the area of health, and to slightly supplement psychotherapeutic guidelines and methodological framework. All main scientific sources, scientific literature reviews and professional guidelines used in the document are listed in Chapter II: "Scientific and professional basis". Rigorous methodological reviews of scientific literature include the sources listed here in point: 3,4,5,21. The state of scientific knowledge and scientific consensus were determined (paragraph 21, chapter II), several sources and guidelines used the GRADE system[262] [263]. Before the document was created, we also conducted our own review of professional

261 https://www.spch.pl/zespol-spch-ds-plci-i-seksualnosci/

262 WPATH-8: Coleman E., Radix A.E., Bouman W.P. et al. (2022). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *Op.cit.*

263 Hembree W.C., Cohen-Kettenis PT, Gooren L. et al. (2017). Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *Op.cit.*

guidelines from around the world, which formed its basis[264]. As a result of this critical review, a group of three professional approaches emerged: affirmative, passive/mixed and comprehensive ("psychotherapy first"). The document was also submitted for evaluation to experts from abroad.

In this study, after considering the state of scientific research and the directions of professional assistance guidelines, while respecting the autonomy of the child or young person and his family, we propose the best model of assistance in our opinion in a comprehensive, integrated, interdisciplinary approach and using, among others, achievements of developmental, personality, clinical and family psychology, as well as non-invasive, safe and scientifically well-grounded methods. We are also guided by the long-term safety and well-being of children and young patients. Our recommendations were ultimately based on these criteria. For individual theses, scientific literature was provided and attempts were made to indicate how well-established this knowledge was. Chapter III describes in detail the medical risks associated with choosing different professional approach paths.

Domain 4. Clarity of presentation

The document contains very clear recommendations, especially regarding diagnosis and therapy. The types of disorders that should be excluded are described in detail, and the types of medical diagnostic tests that are not usually mentioned are also recommended, so that not only doctors, but also specialists in other specialties, or simply parents, have an idea of what set of tests should be performed. In the case of psychological diagnostics, diagnostic areas are also listed, taking into account specific questions, while in the case of psychotherapy, it is recommended to explore the occurrence of specific, described psychological mechanisms. The "psychotherapy" subsection also presents the scope of psycho-social interactions and environmental interventions and BMI control as an important factor affecting self-image.

The document has a quite clear structure. Specific recommendations are grouped into sections and important issues are bolded. The text is divided into paragraphs/points in the following chapters:

I. ANTHROPOLOGICAL FRAMEWORK

II. SCIENTIFIC AND PROFESSIONAL FOUNDATIONS

III. BASIC INFORMATION, TERMINOLOGY AND DEVELOPMENT FRAMEWORK

IV. SOCIAL POLICY AND GENERAL FRAMEWORK FOR PROFESSIONAL SUPPORT

V. DETAILED RECOMMENDATIONS FOR DEALING WITH CHILDREN AND ADOLESCENTS WITH OR SUSPECTED GENDER IDENTITY DISORDERS AND GOOD PRACTICES IN THE FIELD OF DIAGNOSIS AND THERAPY

- Initial Diagnosis
- General Assessment of Somatic Health
- Differential Diagnosis
  - Somatic Differential Diagnosis (including endocrine and genetic)
  - Psychiatric and Psychological Differential Diagnosis
  - Sexological Differential Diagnosis
- Comprehensive Psychological Diagnosis
- Psychotherapy

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Domain 5. Applicability

Chapter V is intended directly for clinicians and is ready as a handy guide in the office of a psychologist, doctor or educator, it contains specific questions and areas of exploration. A meeting schedule was also proposed, along with a description of diagnostic methods (or sources of such methods). At the beginning, the optimal composition of the interdisciplinary team was described and a written psychotherapeutic contract was proposed, as well as a method for the evaluation of the effects of various (three) assistance approaches was offered. We also recommend ongoing suicide risk assessment and quarterly monitoring of the patient's condition in an interdisciplinary team.

Difficulties in application may be the lack of specialized facilities in the Polish health system in the comprehensive approach recommended here, which places the need to form interdisciplinary working teams on the specialists themselves. Another obstacle is the lack of legal regulations and the lack of professional consensus in our country (and elsewhere), especially regarding the stages of diagnosis, which means that many parents do not know that a simple diagnosis of gender dysphoria has little to do with a psychological diagnosis, which is usually omitted, which is the source of many misfortunes, and medical transition is offered in aesthetic medicine clinics on the basis of simple certificates from 2-3 specialists.

Domain 6. Editorial independence

The SPCh Standards were created *pro publico bono*. There were no connections with pharmaceutical companies or clinics or medical transition facilities. None of the people involved received any remuneration for the process of creating them. There was cooperation with the Institute "She and He", which was substantive and organizational in nature (it enabled the main coordinator to devote time to the creation of the Standards - at the same time serving as the president of this organization). Two of the authors also served on the Main Board of SPCh. During the development of the Standards, the working team was also provided with autonomy within the SPCh. The final shape of the SPCh Standards was approved at the meeting of the SPCh Main Board.