Posted on **December 19, 2018**

The Theatre of the Body: A detransitioned epidemiologist examines suicidality, affirmation, and transgender identity | 4thWaveNow

The Theatre of the Body: A detransitioned epidemiologist examines suicidality, affirmation, and transgender identity

Posted on **December 19, 2018**

This article is a long read, and includes detailed analysis of several research studies. Interested readers may want to review the bibliography and familiarize themselves with the relevant studies in order to engage most meaningfully with this post.
As with all articles and comments on 4thWaveNow, the views expressed by the author in this piece are his own.

---

by Hacsi Horváth, MA, PgCert (Sheffield)

I am an adjunct Lecturer in the Department of Epidemiology and Biostatistics at the University of California, San Francisco (UCSF). I'm an expert in clinical epidemiology, particularly in systematic review methods, epidemiologic bias and evidence quality assessment. As a researcher at UCSF, I managed the Cochrane HIV/AIDS Group for over a decade and on several occasions served as a consultant to the World Health Organization (WHO) in their HIV guideline development processes.

For about 13 years, I also masqueraded "as a woman," taking medical measures which suggest, shall we say, that I was completely committed to that lifestyle. Most men would have recoiled from this, but in my estrogen-drug-soaked stupor it seemed like a good idea. In 2013 I stopped taking estrogen for health reasons and very rapidly came back to my senses. I ceased all effort to convey the impression that I was a woman and carried on with life.

At 12, I believed I would grow up to be a woman. I was mistaken.

As you may imagine, I have a lot of anger at transgenderism and its enablers, as well as an "inward bruise" (as Melville called it). I am not a happy camper. I have been badly harmed. However–as a father myself–I am far angrier that thousands of young people are being irreversibly altered and sterilized as they are inducted into a drug-dependent and medically-maimed lifestyle. I'm furious that women and girls are being steamrolled by trans activists into accepting any man who claims to be a woman in sex-segregated changing rooms, prisons, shelters, women's sports, and elsewhere. If any man can simply announce that he's a woman, then what *is* a woman?

My strong feelings often show through in what I write. On Twitter, in blogs and elsewhere online, I have often taken a very strident, confrontational tone. I have offended many with my refusal to utter words that I consider to be unsubstantiated, politically motivated jargon, along with my unrepentant "misgendering," among other sins. In contrast, in real life, I try to get along with everyone and tend to be diplomatic with people whose views conflict with mine. I'm somewhat reclusive and generally not very keen to blast other people with peremptory critique.

1. **Prologue**

Where gender dysphoria (GD) is discussed, "suicide risk" and "transphobia" may lurk nearby, especially when the topic concerns adolescents and young adults (AYA). Why is this so? In this article, I will demonstrate that activists have created the false impression that the risk of suicide in adolescents and young adults (AYA) with GD (AYA-GD) is unique and unparalleled, that AYA-GD suicides are common and that "transphobia" is the main cause of such suicides. I will show why the shockingly high suicide attempt rates they commonly cite are not credible. I will also show evidence that AYA-GD suicide attempt rates are likely similar to those of other populations with similar risk factors. While these rates are higher than in the general population, they are much lower than they are touted to be in transgender activist propaganda.

Finally, I will look at the statistics for completed suicide in AYA-GD, before closing with some observations about losses to follow-up in studies looking into outcomes in people with GD, some years after their trans-related surgeries.

GD is a poorly-defined syndrome comprising one or more mental health problems, commonly including anxiety or depression, among others. It includes a "strong desire" to "be" the opposite sex, or at least to perform its stereotypes. At minimum, patients may have come to believe that they are utterly unsuited to fulfil the stereotypic roles and gestures socially prescribed for their actual sex, even if they have had tremendous lifelong success in doing so, and even though they are quite free to ignore such stereotypes. Gender dysphoria's concomitant cognitive bias may keep the patient from ever getting better.

The reason they may never recover from it is that this cognitive bias tells them this mental illness is really "mental wellness" (Levine 2018). They typically only visit doctors and psychotherapists who are willing (or even eager) to "affirm" their opinion that they are somehow inhabiting the wrong body. They are steered

with increasing ease into a transgender trajectory and the mysteries of "transition." Costume change, with or without cosmetic surgery, is an ineffective means of changing sex. Indeed, changing sex is impossible. "Transition" is thus mostly concerned with personality expression and receiving (in my view) unnecessary medical care. It can begin almost at a moment's notice. In the US, self-diagnosed adolescent and adult GD patients may even receive prescriptions for cross-sex synthetic hormone drugs on the day of their first clinical visit.

Until recently, having GD and "being trans" were considered synonymous. This belief has shifted somewhat, as the phenomenon of "non-binary" people emerged. Also, it's apparently no longer necessary even to have GD to be considered transgender. In San Francisco, if you want to be "trans," they will "rubber-stamp" you and you'll have your genitals inverted (or your breasts will be gone) in no time.
I don't believe GD reflects any kind of problem or glitch in the human body. Here's what I suggest, in broad strokes, is going on with adolescents and adults:

- Heterosexual males (the vast majority of men with GD) have autogynephilia.
- Homosexual males with GD enjoy "femininity" and mistakenly believe this means they are "trans" or even women.
- Females with GD have internalized misogyny and/or internalized homophobia.

In my opinion—which is based upon extensive research, as well as my own 13-year-long experience in pretending to be a woman–GD is only superficially concerned with one's sex. It's more a disturbance of identity, of mistaking the signifier for the signified. Patients have whatever mental illnesses they may have, or that develop while in the ruminations and hypomanic states that typically precede "coming out as trans." I propose that GD is a moody, brooding syndrome that accompanies these mental illnesses. People with GD have cultivated an idealized vision of themselves as the opposite sex. At a critical point of rumination, after the patient has sufficiently disparaged his or her actual life and idealized life as the opposite sex, he or she realizes that body parts of the opposite sex may be obtained through the services of doctors (Raymond 1979, Billings 1982). Actually transforming into the opposite sex starts to seem feasible. The self-conception "splits" in two, and idealization becomes identity.

Having negated any value in their actual male or female presence in the world, and now feeling themselves to actually *be* the self-generated persona, patients perseveratively ask themselves, "what's stopping me?" "Feasibility" seems to trigger the split. Here begins the acute phase of GD.
Patients become obsessed with "transition." To the same extent that they can be energized by the belief that they are making "progress," as their bodies morph via the hormone drugs and shop clerks address them by their preferred honorifics (i.e. Miss or Ma'am for the males, Sir for the females), they can also feel destroyed by any little delay or perceived setback—including being "misgendered" or identified by others as their actual sex. Nothing else matters but "transition." The apparent certainty of these patients, as well as their zeal to continue, is seen by "affirmative care" doctors as evidence of "being trans."

Gender is a hierarchal framework that stratifies and categorizes "masculine" and "feminine" attributes and behaviors. In the context of transgenderism, it is also a convenient rhetorical device to elide the problem of sexed bodies and to label oneself as endorsing one or the other sets of sex role stereotypes. Earlier articulations of GD as "gender identity disorder" made more sense, but it seems that most people understood it to mean "having an opposite-sex gender identity." I would suggest that it may more accurately be understood as simply an identity disorder, a disordered or disturbed identity, with a fixation on gender.

I agree with the late French psychoanalyst Colette Chiland when she said: "Transsexuals stage everything in the theatre of the body, and nothing in that of the psyche" (Chiland 2003). It is true that persons in the driven, obsessed stages of gender dysphoria can seemingly think of nothing except transition. No-one dreams of asking them to slow down, to seek psychotherapy, perhaps even find a way through this work to prevent transition, which can be costly on so many levels. It would be like standing in the way of a bolting, bucking

horse. The fact that people with gender dysphoria are like this is a sign that something is wrong, yet they are not impeded at all.

But doctors are doctors and patients are patients. These surgeries and lifelong hormonal drug regimens didn't used to be given out like crackerjack prizes. Virtually no research has been done in psychotherapeutic methods to alleviate the symptoms of gender dysphoria, prevent it, or get rid of it altogether. The entire literature comprises a couple of dozen case reports and small case series, some promising, nearly all from before 1990, and all using archaic methods. Based primarily on the pronouncement of Harry Benjamin, the "godfather" of transsexualism, that psychotherapy with these patients was a waste of time, the medical profession increasingly found ways to justify surgical and hormonal transition as the standard of care (Billings 1982). I will get back to this near the end of the article.

The biggest risk factor for continued large increases in GD may be the normalization of what has become common practice: that people with a variety of problems in life, or even just confusion, should be able to self-diagnose as trans, be celebrated and congratulated as such, and then turned into permanent patients. In North America and the United Kingdom, and perhaps in other settings, even children's schools seem to operate as factory farms for transgenderism, with a pseudoscientific curriculum that disseminates transgender ideology.

"Affirmative" harms

There are three main models for treating children and adolescents who seem to have GD (Byne 2012, Costa 2016, Ristori 2016). The most sensible one helps kids to become more comfortable with who they are in material reality (Byne 2012, Costa 2016, Ristori 2016).

Another at first glance appears neutral about the question of whether the child should have a normal life or become a transsexual and therefore a permanent patient. Children subject to this strategy are often given drugs to block their puberty (Byne 2012, Costa 2016, Ristori 2016). Ostensibly, this is done to "give them time to decide," but while deciding (and emulating the opposite sex) they surely become more deeply invested in rocketing further down that road.

The most hazardous approach of all is "affirmative care" (Byne 2012, Costa 2016, Ristori 2016), which is mainly seen in North America. According to this model, young people and adults who keenly desire to emulate opposite sex stereotypes, or perhaps show an indication that they might someday be homosexuals, are assured that they definitely "are trans," and that it is essential to help them transition immediately (Byne 2012, Costa 2016, Ristori 2016). This model even encourages toddlers to "socially transition," with boys being indoctrinated into stereotypic femininity and "girlhood," and girls into masculinity and "boyhood." Yet social transition has been shown to be predictive of persistence of GD (Ristori 2016). This means that even though young children nearly always desist from believing they are the opposite sex, socially transitioned kids are much more likely to begin puberty-blocking drugs at age 8 or 9, and then carry on with the rest of the complex medicalized transition process. If parents make any objection or refuse to "affirm" their child's plan, they are shamed and belittled as "transphobes." In some instances, parents can even be prosecuted and have their children taken away by the government.

Under the affirmative model, adolescents and adults are generally enabled to pursue medical interventions right away, seldom being told by their doctors "no, you are making a mistake."

In this article, when I speak of trans activism, trans ideology and the like, I am referring especially to the "affirmative care" model. The old "gatekeeping" of patients with gender identity problems, which was developed in the 1950s to keep these often mentally unstable persons from rushing into irreversible, experimental interventions, is a ghost of what it once was. In cities like San Francisco, it has essentially been replaced by "informed consent" – which in practice translates to "on demand."

Proponents of affirmative care have dealt the deathblow to what little gatekeeping that remains. Their activities could well be described as marketing and recruitment for "being trans." Patients of any age need only say they think they are really the opposite sex, or wish they were, and affirmative care clinicians are happy to get busy, scheduling surgeries and prescribing lifelong drug regimens. They seem to see themselves as affirmative pioneers, especially those who work tirelessly to provide medical interventions to more and more children and teens, thus creating an iatrogenic illusion from which the kids may never emerge. A few examples follow.

Dr. Johanna Olson-Kennedy of Children's Hospital Los Angeles is a prominent affirmative care physician. Earlier this year at a gender conference, she described radical mastectomy outcomes in gender-confused girls as young as age 13. She doubled-down on this affront to Hippocrates by suggesting that if teen girls later regretted the loss of their breasts, they could "go and get" new breasts, suggesting that breast implants would make them as good as new. There has been a tremendous surge over the past decade in girls and young women presenting to gender clinics (Zucker 2017, Littman 2018), and Olson-Kennedy says she has personally ushered more than 1100 of them into the medicalized trans lifestyle.

In a 2018 paper, she recommends referring girls for this "top surgery" first, and only afterwards prescribing testosterone – thus removing the option for what might have been a little more time to think through this irreversible decision (Olson-Kennedy, 2018).

At the Kaiser-Permanente Medical Center in Oakland, California, surgeons have removed healthy breast tissue from gender-confused girls as young as age 12.

Psychologist Dr. Diane Ehrensaft of University of California, San Francisco (UCSF) is keen for toddlers and small kids to begin a "social transition" and likely continue along the path to medical transition (Ristori 2016). As mentioned above, children and adolescents no longer need to have GD; all are welcome to begin transition. At a symposium earlier this year, UCSF paediatrician Dr. Ilana Sherer told of feeling "challenged" when "lots and lots of kids" presented to her gender clinic without feeling any gender dysphoria. The "challenge" to which she alludes is that insurance companies (rightly) require evidence that these kids are receiving psychological support before the company agrees to cover the trans-related medical interventions they seek. Sherer spoke of the solution to this problem. After a brief meeting with a child, Ehrensaft (as Sherer describes it) essentially "rubber-stamps" the youth's paperwork so that insurance companies will pay.

In other words, she is approving services for patients who not meet diagnostic criteria and indeed do not have any distress. A question comes to mind: are health insurance companies and/or the health care fraud division at the US Department of Health and Human Services aware of this practice? It seems likely that if they knew, they would feel quite "challenged" to let it just go on.

Cross-sex hormone drugs have a drastic effect on the body and carry serious health risks. Notwithstanding this, UCSF's guidelines suggest that almost anyone is qualified to prescribe a lifelong regimen of the drugs – even physician assistants, naturopathic providers (!) and nurse midwives. It is unclear why the MTF author of these guidelines, Dr. Madeline Deutsch, who trained as an emergency room physician, thought this would be wise. A healthy endocrine system's ecological balance can easily be thrown into chaos – which is what happens when one takes cross-sex hormones anyway.

So, these are some of the better known members of the clinician crowd I am speaking about most directly in this article. Their approach is not the global standard – its recklessness seems clear to most people outside North America – but they are certainly marketing it aggressively.

2. **Weaponizing our instinct to protect the vulnerable**

Few things in life break our hearts more than to learn of a young person's death, especially by suicide. We can't help but have an emotional response to such news. The trans industry – comprising the activists,

academics, healthcare providers, clinics, and pharmaceutical companies that benefit from transgender ideology, financially or otherwise – understands this well. The spectre of suicide in AYA-GD is a key component of trans activism. Not merely a talking point, it is a truncheon that activists and trans industry clinicians, other industry partners and virtue-signalling "allies" wield to force full compliance with their demands. To prevent trans suicides, the trans industry requires nothing less than a world that is utterly purged of transphobia.

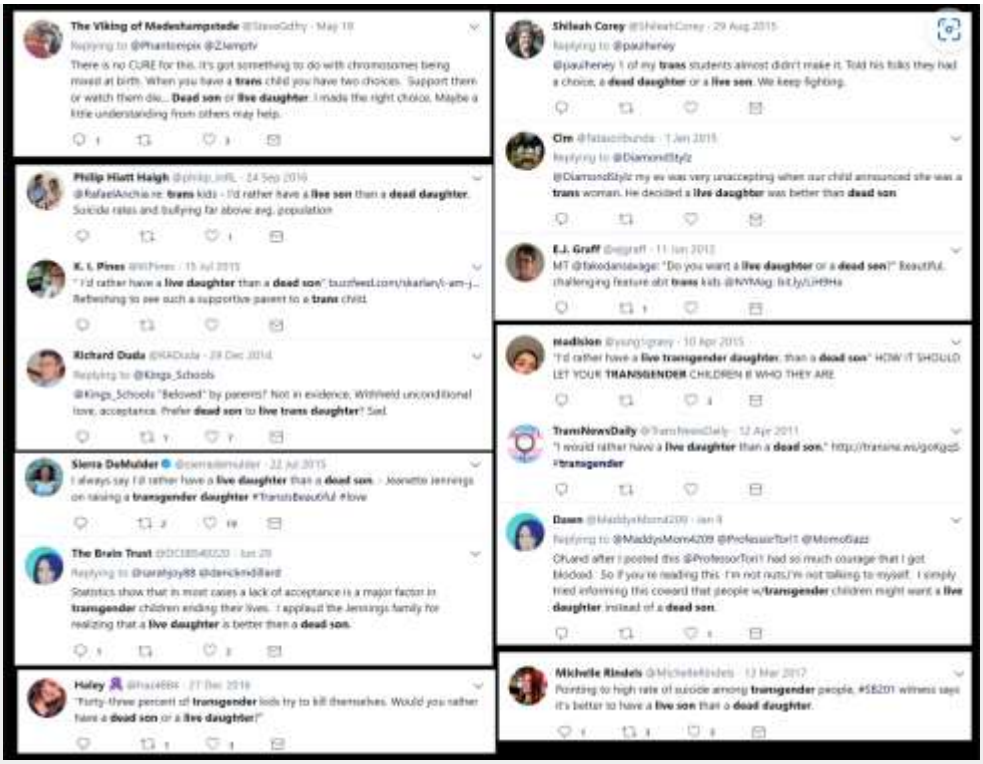
Well, what is transphobia? Is it, as activists insist, a type of "hatred" that people who are not confused about the sex to which they belong ("cis," in industry jargon) aim at the oppressed, still emerging masses of women and men, boys and girls who were "born in the wrong body"? No, of course not. Criticizing transgender ideology has nothing to do with hate and everything to do with mammalian evolution over the past 200 million years, the scientific method and common sense.

Then is it really homophobia, perhaps? Yes, in some cases it might be, because (in my view) no one is actually "trans." Gay men and lesbians who take the transgender path are still essentially gay men and lesbians. But transphobia is much, much more than this.

"That's transphobic."

In real terms, transphobia could be defined as anything that an ordinary person does, says or even believes that "invalidates" transgenderism and its core principles, or invalidates any belief of a person claiming to be trans. In other words, factually stating that men cannot become women, nor can women become men, has a high probability of increasing GD in any trans persons within earshot. It would be considered transphobic. When a "trans woman" is made to feel that it is inappropriate for him to be in the women's restroom or changing room, he feels tremendously dysphoric and "invalidated."

Similarly, to "misgender" a trans person – to accurately refer to a male with masculine pronouns, or a female with feminine ones ("gender" does, after all, exist in the grammar of many languages) – can send dysphoria through the roof, as validation plummets. People need to feel validated! But validating a lie so they might feel better for a minute is not helpful. Trans activists insist that misgendering is an "act of violence" that "literally kills" – meaning that being addressed with the wrong pronoun might drive them to suicide.



A common meme on social media.

Why do many clinicians and other educated people go along with this nonsense? The trans activists insist on "validation" in everything they do or say, without objection. Objections or disagreement are transphobic. Any utterance or action that increases GD for anyone is transphobic. Unwillingness of society or any individual to accommodate any desire of men or women claiming to be trans is transphobic. Mirrors are transphobic. Biology is transphobic. Reality is transphobic.

Lifesavers

In contrast, every type of medical or social intervention for the supposed benefit of people with GD, especially youth, is described as "life-saving." The refrain of "life-saving" echoes everywhere in the discourse around this topic. This has been a key strategy in convincing people that major surgeries are a "medical necessity" – "the basic healthcare they need to survive." According to the trans industry and its friends, spikes in GD due to transphobia seem to lead almost automatically to AYA-GD wanting to end their lives. It is as if they are always on a ledge, ready to jump.

This incessant repetition of purported suicide risk is like a strange new variation of Munchausen syndrome by proxy, wherewith trans activist adults and some clinicians effectively threaten suicide on behalf of the young people. They do this to socially-engineer, manipulate and intimidate non-industry doctors, politicians, community leaders and families of AYA-GD. They are well aware of the emotional responses they will get with this rhetoric. Meanwhile, experts in suicide prevention have always recommended against strongly emphasizing suicide risk in a given population.

On a related tangent, clinicians in the earlier days of proper gatekeeping often reported that their male trans patients commonly used manipulative suicide threats to get more rapid approval for hormone drugs and genital de-masculinization surgery (Burchard 1965, Pauly 1965, Limentani 1979, among others).

Most parents and other reasonable adults would easily reject the notion that healthy adolescents urgently need hormonal and/or surgical intervention so that they can be their "authentic selves." It doesn't make any sense. They're healthy; and until a few weeks or months ago she was just an ordinary girl, he just an ordinary boy. However, activists and industry clinicians mess with everyone's sense of reality by insisting that without such "care," there's a fair chance these suddenly troubled youth will commit suicide. Parents and policy makers alike are thus terrorized into going along with trans ideology, and the general public begins to believe it's true.

Suicidal behaviour is learned (Strosahl 2006). The degree to which AYA-GD have internalized the notion that they may not live long is disturbing: Most seem to have taken on board not only that they are abnormal, hated by the "cis" world, but that they are also expected to kill themselves. On a mobile phone app called Whisper, thousands of AYA-GD create these "posters" in which they briefly express what's on their minds, and people respond. It's tragic and alarming that many of these young people are apparently in such deep distress, especially when the reasons for this distress are not true. They have been manipulated into a cultish belief system.

On the other hand, suicidality is so ingrained in their consciousness that they almost seem to threaten suicide as a way of saying hello, to establish commonalities.

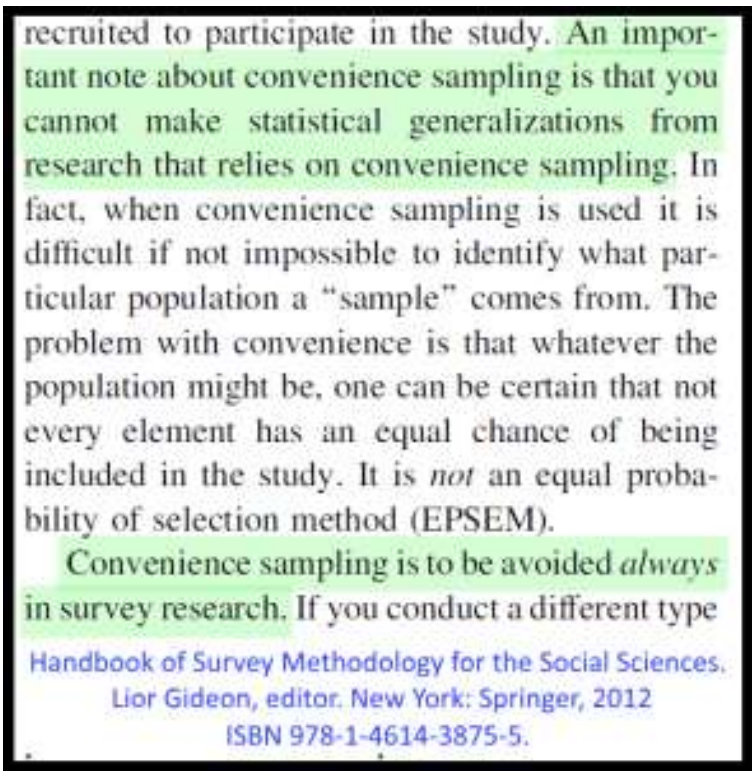
Surveys of attempted suicide rates

How serious are these young people? It may indeed be true that AYA-GD attempt suicide at higher rates than most other AYA, but these rates are not uniquely high, as I will soon show. They are also likely lower than the shockingly high estimates frequently broadcast through trans activism. Completed suicides in AYA-GD are rare, and estimates of suicide attempt rates do not translate into rates for completed suicide. There are around 100 to 200 suicide attempts for every completed suicide in adolescents (Sarchiapone 2016). Suicide

attempts may vary greatly in both the seriousness of the effort and the lethality of the method used (Liotta 2015). "Cutting" or other forms of non-suicidal self-injury may be construed as suicide attempts. Suicidal ideation is even further removed from completed suicide.
I'm now going to critically appraise the most commonly cited surveys of suicide attempt rates in AYA-GD and other relevant populations, and then we'll look at some of better quality. Fair warning: The following sections delve into research methodology to an extent some readers may have difficulty following. I would suggest reading the cited studies (if you haven't already) for context and to aid in understanding the points I'll be making.

Surveys in AYA-GD & adults with GD. Several surveys have tried to quantify the rate of attempted suicide in adults or adolescents with GD. In general, one can say that the flimsier the survey methods used, the more likely the estimates will not reflect reality in the population being studied. Many have heard about survey results suggesting that over 40% of adults (Haas 2014, James 2015) or adolescents (Toomey 2018) who identify as transgender have attempted suicide at some point in life. There is good reason to mistrust the accuracy of these claims, as two surveys in adults (Haas 2014, James 2015) were inherently at high risk of bias due to their design; the other in adolescents (Toomey 2018) for a similar reason, as well as a high risk of bias due to extreme looseness in survey data collection.

Non-probability convenience samples, such as those used in the above surveys, are not appropriate to use when trying to quantify an outcome (such as suicide attempts) in a given population (Gideon 2018). It is a rather haphazard means of data collection.


recruited to participate in the study. An important note about convenience sampling is that you cannot make statistical generalizations from research that relies on convenience sampling. In fact, when convenience sampling is used it is difficult if not impossible to identify what particular population a "sample" comes from. The problem with convenience is that whatever the population might be, one can be certain that not every element has an equal chance of being included in the study. It is *not* an equal probability of selection method (EPSEM).

Convenience sampling is to be avoided *always* in survey research. If you conduct a different type

Handbook of Survey Methodology for the Social Sciences.
Lior Gideon, editor. New York: Springer, 2012
ISBN 978-1-4614-3875-5.

Unfortunately for the researchers conducting these surveys, their use of convenience samples pretty much guaranteed that their estimates would be far off the mark. Citing estimates from such surveys, let alone hyping them, is inappropriate (Gideon 2012). They each needed a sample that was representative of the populations in question, and to obtain that they would have needed to use probability sampling methods. These are more complex to implement. Even so, it is unclear why they didn't do so, especially in the case of the National Transgender Discrimination Survey (Grant 2011), which was analyzed by the Williams Institute (Haas 2014), and the US Transgender Survey (James 2015). Judging by their very lengthy and glossy

published reports, these projects seemed to have more than sufficient resources to do their surveys correctly.

The latter survey (James 2015) seems to have had an identity crisis in terms of its sampling methods. The document claims in two places to have used convenience sampling and in one place to have used purposive sampling. Purposive sampling is typically used in qualitative research when a comprehensive, "saturated" understanding is desired. Researchers seek informants who have abundant experience and expertise. This method has an intentional selection bias. In describing its supposed "purposive sampling" method, the document lists "direct outreach" (by which was meant convenience sampling) and then several methods for network sampling.

Network sampling is commonly used in HIV research in developed countries to reach "hidden" or stigmatized populations, such as injection drug users. In countries where it is illegal for men to wear women's clothing & accoutrements, let's say in Uganda, HIV prevention researchers will commonly use respondent-driven sampling, snowball sampling and other network sampling methods to find such men. Doing this in the United States in 2014 would likely have resulted in responses from injection drug users or people with serious mental illness who were also transvestites. That may be fine if the survey's goal is to collect data from people with big problems in their lives, but it is not appropriate for obtaining representative data from the population of interest (Heckathorn 2017).

In any case, the vast majority of US Transgender Survey data were definitely collected through convenience sampling, such as advertising on various websites and other simplistic efforts. It was not a purposive sample. Any data collected through their alleged network sampling methods would likely have made their findings even less representative of the US population who believe themselves to be transgender.

This is not to say that convenience sampling is always bad. No indeed – there are certainly appropriate uses for convenience samples. Researchers may use convenience samples when they wish to make a rapid, exploratory assessment of a new or changing phenomenon, such as rapid onset gender dysphoria (ROGD) and other epidemic outbreaks. Data can be collected more quickly than when probability-based methods are used, and can then inform the development of more rigorous research, which may (or may not) replicate the initial findings. Convenience samples are fine to use if researchers wish to describe and even quantify the characteristics of the sample itself. They are not fine if the goal is to extrapolate from the sample to describe or especially to quantify characteristics of the overall population (Heckathorn 2017).

A closer look at the recent paper by Toomey et al (2018). Some may object that the study by Toomey and colleagues did not use a convenience sample. At first glance, it may not seem so. Indeed, with the large overall sample size mentioned prominently in the abstract, it may have the appearance of a rigorous study. However, even Toomey acknowledges that the sample was unlikely to be a representative one.
Consider what transpired prior to the authors' obtaining survey data for more than 120,000 adolescents from a Minnesota-based organization called "Search Institute."

Over a period of three years (2012-2015), the company had sold its do-it-yourself survey services to an unknown number of school districts in various regions of the US (not reported, but said to be "national in scope"). After the Search Institute provided a complicated instruction book to officials from each district, the schools were on their own in administering the surveys. Schools could decide for themselves who would be in charge of administering the survey, whether it be the school principal, math teacher, bus driver, football coach or someone else.

Students completed the surveys online. The company received the survey data from each school, analysed it, and sent reports of these analyses back to the districts.

For the school districts, a well-conducted survey that reached all or nearly all of the district's students, as a census would do, could potentially provide very good data. It's rather different when you conduct a secondary analysis, as Toomey and colleagues have done, of aggregated data from the unknown number of school districts. Even if every student in every one of these districts was reached, the data mean very little at the national or international level. The sample has very little if any generalizability to the broader population. In fact, after the data are pooled, these data no longer have particular relevance to any of the individual school districts. At this point these are just some mixed data that happened conveniently to be available. They are not representative of anything except that collection of districts, *en banc*.

This would still be all right if, for example, these specific school districts were exactly all the school districts in a given region, and you were only interested in responses from youth in that specific region – but this is not the case.

There are indications in the article that things may not have gone so well with these surveys. For example, Toomey reports overall 12-month suicide attempt data for all survey respondents at 14.1%. He suggests that this figure is "consistent with" the 12-month suicide attempt rate in the US Centers for Disease Control and Prevention's (CDC) 2015 Youth Risk Behavior Surveillance System (YRBSS) survey finding of 8.6%. Inexplicably, Toomey also throws in CDC's estimate for "made a plan to attempt suicide" of 14.6%. Making a plan is not the same as actually attempting suicide. An estimate of 14.1% is not consistent with an estimate of 8.6%. It's an overestimation by close to 40%. If we are paying attention, we see this discrepancy as a sign that the Search Institute's aggregated survey data are not even relevant to the general population of youth.

Following this, it is time to figure out just who is being surveyed. Recall that the article's title is "Transgender Adolescent Suicide Behavior." This reader was surprised and somewhat impressed to read that data from "N = 120 617 adolescents" were "used to achieve [their] objectives." Surely the aggregated survey data didn't include that many trans youth. Indeed, they only looked closely at data from a few hundred such youth, a tiny subset of that much larger number. Why prominently mention the overall number when the analysis is only about those who say they are trans? It might have been appropriate to mention the larger number, as long as they also reported there the number of respondents whose data they examined.

Toomey and colleagues set themselves up for additional failure by including responses from kids who did not even claim to be trans. The fact that survey data came from youth as young as age 11, unlikely to have become fluent in trans ideology quite yet, compounds the problem of trans being some kind of an umbrella, a cookie, a unicorn or whatever else one wants it to be.

Table: Self-description of trans-identified respondents in Toomey 2018

Category	Number identifying as such
"transgender, male to female"	202
"transgender, female to male"	175
"transgender, not exclusively male or female"	344
"not sure"	1052

So, the big 120,000+ number reported in the abstract was a sleight-of-hand manoeuvre for the reader in a hurry — cooked up to convey the false impression that this was a seriously large pool of data. It was actually quite small. I say again, we have no evidence that anyone in the world "is transgender" – born with some essential or innate gender identity that is "incongruent" with their biological sex. Even if "being trans" in any

essential way were as real as paint, these researchers have data from fewer than 400 adolescents, along with a few hundred kids who claim to be "non-binary" and another thousand or so who have no idea what they're supposed to say.

Next, Toomey and colleagues report that suicidal behaviour history was assessed with just one question: "Have you ever tried to kill yourself?" The question is direct, but experts in designing surveys for assessing suicidality suggest that overestimates are less likely if respondents are asked several times, in different ways (Strosahl 2006, Horn 2016).

Contrary to the assurances of Toomey and colleagues (2018), detailed methods for this survey were not available on the Search Institute website. Some cursory characteristics were provided, but these were on the order of advertising. A "user guide," intended for the use of school personnel conducting the survey, highlighted the difficulties that school administrators, teachers and other staff might have in preparing for and administering this survey. They are encouraged to take a National Institutes of Health online training in ethical conduct of research with human subjects. They are told that a "census" survey method would be best to use, but are immediately given instruction in estimating necessary sample sizes and in methods for conducting systematic random sampling. It is unlikely that most of these school districts had staff on hand who were up to the task of conducting the survey with competence. The truth is we have no idea what happened in those schools or how faithful they were in following the user guide. The Search Institute organization left school districts to their own devices. With a Search Institute employee as a co-author, Toomey and colleagues (2018) may have known more detail about the schools and how data were collected, but they do not report it.

Finally, Toomey and colleagues (2018) calculate adjusted odds ratios to estimate probabilities of suicide attempt by demographic characteristics and "gender identity." They needn't have gone to the trouble. It gives their analysis a simulation of gravitas, but given the "convenient," admittedly non-representative data, there's no reason to believe that these estimates are anywhere close to accurate.

Better quality surveys of AYA-GD. Interestingly, in addition to analysing data from the survey reported by Haas and colleagues (2014), the Williams Institute at University of California, Los Angeles, also conducted one that was much more rigorous (Wilson 2017). This organization was contracted with the state of California in 2015-2016 to survey a sample of adolescents in the state. They were required to use much stronger methods than had been used in the other surveys or their other implausible analyses. For example, instead of asking respondents who happened to be nearby to fill out surveys online, they used trained interviewers who spoke over the telephone directly with each adolescent. Among other aspects, this enabled them to clarify any potential misunderstandings. Unlike the other surveys, questions about suicide attempt history in the California Health Interview Survey (CHIS) were asked in several nuanced variations, reducing the potential for an overestimate (Strosahl 2006, Stone 2016). Also, in contrast to the other surveys which used convenience samples and were not intended to be representative of the population (Haas 2014, James 2015, Toomey 2018), this survey was intended to be representative of California's adolescent population (Wilson 2017).

The CHIS did not explore GD or whether students considered themselves to be trans, but it did explore degrees of gender nonconformity. I realize that these are not the same. In our current epidemic of ROGD (Littman 2018), I would suggest that data from students whose personality & style expression is strongly at variance to that of their respective sex stereotypes might serve as a proxy for data from students who considered themselves to be trans. If a boy today endorses that he is "very feminine" or a girl that she is "very masculine," I'd bet a dollar that these kids believe they are trans.

Only 3% of adolescents ages 12-17 who thought their peers regarded them as "very masculine" (if girls) or "very feminine" (if boys), categorized as "highly gender non-conforming" by investigators, reported having

attempted suicide. This rate was statistically similar (i.e. not different) to the 2% rate reported by peers who felt other students considered them to be "gender conforming" (Wilson 2017). Considering that no one yet has adequately defined "trans" and that GD's diagnostic criteria are similarly hazy, the survey with stronger methods may provide a more accurate picture of AYA-GD attempted suicides than the ones with weaker methods. It's a bit unclear, as "highly gender nonconforming" youth are not necessarily the same as youth with GD – though one would expect youth with GD to be highly gender nonconforming.

On the other hand, it **is** rather telling that the file name of the Williams Institute report actually includes the phrase "transgender teens." I'm pretty sure this is what they meant by "highly gender nonconforming."
A parallel survey conducted by the same team in California in adults ages 18-70, who were explicitly asked if they considered themselves to be transgender, found that 22% reported suicide attempts (Herman 2017). The authors do not comment on their institute's previous finding of nearly double that proportion in trans adults across the US as a whole (Haas 2014).

Mental Health Indicators for Youth Ages 12 to 17 by Gender Conformity Level, 2015-2016 CHIS

	Highly GNC (n=59)		Androgynous (n=331)		All GNC (n=390)		Gender Conforming (n=1,204)	
Measure	Estimate	95% CI	Estimate	95% CI	Estimate	95% CI	Estimate	95% CI
Suicidal thoughts, lifetime	14%	(4%, 41%)	21%	(11%, 35%)	19%	(11%, 31%)	11%	(6%, 17%)
Suicidal attempts, lifetime	3%	(0%, 24%)	5%	(1%, 19%)	5%	(1%, 15%)	2%	(1%, 6%)
Severe psychological distress, past year	15%	(3%, 48%)	18%	(9%, 34%)	17%	(9%, 31%)	7%	(4%, 12%)

Wilson et al 2017

In any case, the Williams Institute's "highly gender nonconforming" adolescent estimate of 3% is lower than that of the CDC's well-conducted YRBSS survey of high school students (of any level of gender conformity) across the US. In 2017, the survey found that 7.4% reported ever having attempted suicide, down from 2015's estimate of 8.6%, mentioned above.

Lowry and colleagues (2018) conducted a secondary analysis of CDC 2015 YRBSS data, focusing on students in two urban California school districts and one in Florida (n=6,082). As with the Williams Institute survey, investigators explored gender nonconformity, not GD or "trans" status. They found that 23.5% of urban high school girls who felt peers considered them to be "somewhat masculine" reported a suicide attempt in the preceding 12 months. Investigators did not report separately the proportions of girls who said they were seen to be "very" or "mostly" masculine, because there were fewer than 30 responses for each. Instead, they pooled data for these with the "somewhat" masculine responses. In this composite category, 20.5% of girls had attempted suicide in the preceding year. However, this was not statistically associated with their gender nonconformity (adjusted prevalence ratio [APR] 1.60; 95% confidence interval [CI] 0.81 to 3.16). Gender nonconformity was not associated with suicide attempts in any of the other female "masculinity" categories.

In "very feminine" urban boys, 14.7% reported suicide attempts, compared to 17.7% and 26.4% respectively in boys who thought they were perceived to be mostly or somewhat feminine. In somewhat, mostly and very masculine boys, suicide attempts were reported by 6.1%, 3.4% and 4.6%, respectively. In "equally masculine and feminine" boys, 9.3% reported suicide attempts. However, researchers could not directly associate these rates with gender nonconformity in any of the somewhat, very or mostly categories. In other words, several factors besides being highly gender nonconforming likely played a role in the suicide attempts of somewhat, mostly and very feminine boys.

There are other adolescent populations besides trans youth whose lives commonly include significant challenges. Suicide attempt rates in these populations are similar to those in "highly gender nonconforming youth" that we have seen with the better quality surveys. We already know that adolescents and adults with GD tend to have much higher psychiatric comorbidity than the general population (Hepp 2005, Duišin 2014, Heylens 2014, Connolly 2016, Reisner 2016, Wise 2016, Alastanos 2017, among the more recent references). Indeed, before making such clinical observations put one at risk of breaking the law (or at least being banned from Twitter), numerous clinicians observed that the personalities and behaviors of their patients with "gender identity" problems were often consistent with those of people with borderline personality disorder (Hoenig 1974, Levine 1981, Meyer 1982, Lothstein 1984), a condition with higher suicidality than the general population.

Rates of clinically significant psychopathology in youth referred to gender clinics are similar to those of youth referred for non-gender reasons to mental health clinics (Kaltiala-Heino 2018). We also know that many are gay or lesbian. Many also have experienced bullying. Let's look at what well-conducted surveys sampling these other populations more specifically have found.

Survey in youth with mental illness. Around 96% of adolescents in the US who attempt suicide meet lifetime criteria for at least one mental illness (Nock 2013). The most prevalent DSM-IV disorders found in youth attempting suicide included major depressive disorder, eating disorders, attention-deficit/hyperactivity disorder, conduct disorder and intermittent explosive disorder (Nock 2013). Personality disorders are seldom assessed.

Husky and colleagues (2012) with the US National Co-morbidity Survey conducted computer-assisted face-to-face interviews with more than 10,000 adolescents ages 13-18. In youth with any psychiatric condition (n=2,341), 6.8% had attempted suicide in the preceding 12 months. In youth diagnosed with mood disorders (n=1,021), 14.4% had made an attempt in the preceding year. The proportions respectively for substance use disorders, anxiety disorders and disruptive behaviour disorders were 8.3%, 6.0% and 11.7%. Numbers were small (n=76) for youth with eating disorders, but 26.9% had attempted suicide in the preceding 12 months (adjusted odds ratio 11.40, 95% CI 3.18 to 40.87).

Survey in sexual minority youth. Sexual minority adolescent (i.e., lesbian, gay and bisexual) populations face similar challenges to trans-identified adolescents. Indeed, there is very significant overlap of the populations, as many trans youth identify (or formerly identified) as lesbian or gay.

Stone and colleagues (2014) analysed CDC YRBSS data from five US metropolitan regions for the years 2001-2009, with the objective to identify suicide risk factors in sexual minority youth. They aggregated data and stratified those for youth who declared their sexual orientation to be heterosexual, lesbian, gay male, bisexual or unsure. Investigators do not report the overall denominator of adolescents surveyed, but 20,545 reported ever having attempted suicide. Summary data for reported suicide attempts, stratified by sexual orientation, are presented in the table below.

Table: Prevalence of sexual minority youth suicide attempt and medically serious suicide attempt, five US cities, 2001-2009

Sexual identity (females)	Lifetime suicide attempt	Medically serious suicide attempt
Heterosexual	8.8%	2.2
Lesbian	28.3%	9.0
Bisexual	30.1%	8.0

Unsure	17.9%	4.4

Sexual identity (males)	Lifetime suicide attempt	Medically serious suicide attempt
Heterosexual	6.8%	2.7
Gay	23.4%	8.7
Bisexual	26.4%	11.6
Unsure	18.2%	9.8

These 2001-2009 estimates seem somewhat higher than estimates using composite data from the 2017 round of the YRBSS, showing that in students self-describing as lesbian, gay or bisexual, 23.7% (95% CI 19.4 to 28.5) of girls and 18.3% (95% CI 11.5 to 27.9) of boys had attempted suicide in the preceding 12 months, with an overall estimate of 23.0% (95% CI 18.6 to 28.0) (CDC 2018). This suggests that suicide attempts may be declining in this population. Medically serious suicide attempts were reported by 7.5% (95% CI 5.7 to 9.8) of lesbian, gay or bisexual youth (CDC 2018).

Survey in youth who have been bullied. Messias and colleagues (2014) analysed data from the CDC's 2011 YRBSS to determine the impact of bullying on suicidal behaviour in adolescents. In youth who reported any bullying victimization, either school bullying or cyber-bullying (n=3429), 24.7% reported ever having attempted suicide in the preceding 12 months. In youth who reported both school bullying and cyber-bullying (n=1,122), 21.1% reported a suicide attempt (Messias 2014).

How well can we believe any of this evidence? Finally, in regard to the evidence from all of these surveys, it's important to remember that according to the global standard GRADE approach to assessing the quality (certainty) of scientific evidence, even the population-based surveys using relatively strong methods would contribute only very low-quality evidence. I have not given it a full analysis, which would require a systematic review to be done, but that's my quick informal assessment. Very low-quality means that the true proportions could still be quite different from these estimates. In the surveys with weaker methods, well, let's just say they don't inspire much confidence.

Survey	Population	Method	Timeframe	Suicide attempt
CDC YRBSS / Lowry 2018	"Highly gender nonconforming" adolescents across USA	Three-stage cluster sample	Past 12 months	23.5% girls 14.9% boys
CDC YRBSS / Stone 2014	Sexual minority (lesbian, gay, bisexual) youth in five US cities	Three-stage cluster sample	Inconsistent among sites; investigators treat composite data as "ever"	28.3% lesbian 30.1% bisexual F 17.9% unsure F

			Data collected 2001-2009	23.4% gay 26.4% bisexual M 18.2% unsure M
CDC YRBSS / main report	Sexual minority (lesbian, gay, bisexual) youth in 38 US states	Three-stage cluster sample	Past 12 months Data collected 2017	23.0% overall 7.5% of attempts were medically serious
CDC YRBSS / Messias 2014	Youth who experienced bullying in 38 US states	Three-stage cluster sample	Lifetime Data collected 2011	School or cyber: 24.7% Both school and cyber: 21.1%
National Co-morbidity / Husky 2012	Adolescents with DSM-IV diagnoses	Multistage household probability	Past 12 months Data collected 2001-2004	6.0%-26.9%
California Health Information Survey (CHIS) / Wilson 2017	“Highly gender nonconforming” adolescents ages 11-17, California, USA	Dual-frame, random digit dial	Past 12 months Data collected 2015-16	3%
National Transgender Discrimination Survey	Adults ≥18 yrs self- identifying as trans or “gender non-conforming, USA	Convenience	Lifetime Data collected 2011	41%

Toomey 2018	Adolescent students in an unknown number of schools across US, though not large cities	Convenience	Lifetime Data collected 2013-2015	48%
US Transgender Survey	Adults ≥18 yrs self-identifying as trans, US	Convenience	Lifetime Data collected 2015	40%

3. **Completed suicides**

If transphobia were really driving large numbers of AYA-GD to suicide, we would need to get a handle on what those numbers might be. Let's try.

Wikipedia's "List of LGBT-related Suicides" lists 11 names of people deemed trans. The first trans name listed is that of a man who died in 2009. Next is the suicide of troubled teen, Joshua "Leelah" Alcorn of Ohio, USA, in December 2014. His death was heavily exploited by trans activists and the mass media covered the tragedy quite intensively for several weeks. There were even death threats made to Alcorn's parents. According to the Wikipedia suicide list, eight additional AYA-GD took their lives in the five months following Alcorn's death. Although this Wikipedia page has been edited dozens of times since mid-2015, no additional "trans" names have been added to the list since then.

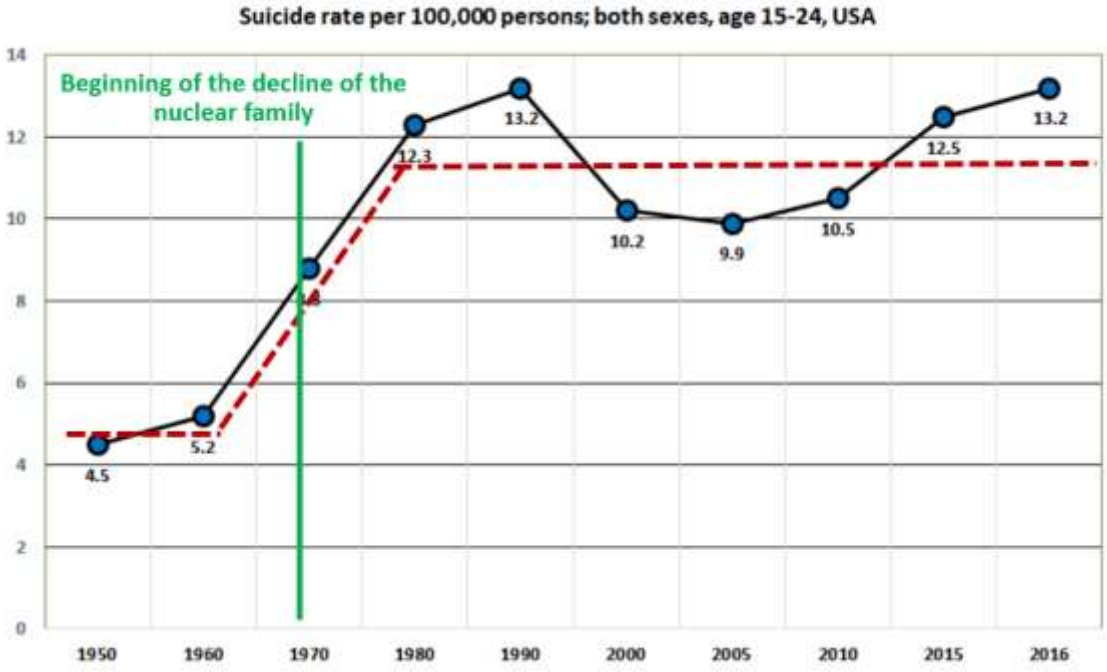
By no means am I suggesting that anything is proven by this, or that anything on Wikipedia should even be believed. I do want to point out that if it were true that large numbers of AYA-GD were dying at their own hand, that list would likely be a great deal longer. The other thing I want to highlight is the apparent contagion of Alcorn's suicide to several other AYA-GD. Around 5% of all youth suicide can be attributed in part to discussion and media coverage of other suicides (Kennebeck 2018).

People don't kill themselves for just one reason, like feeling worried about the future (the main theme of Alcorn's suicide note). It's a complex behaviour that may have several factors contributing to the decision. The most prominent of these are mood disorders and other types of mental illness (Gili 2019). Others include "all or nothing" thinking, substance abuse, a family history of suicide and feelings of hopelessness. Another important contributing factor is exposure to other suicides (Strosahl 2006) and news and discussion about suicides.

Real conditions. It is certain that suicide remains a serious problem in AYA, with or without GD. Overall, suicide is the third leading cause of death in AYA ages 15-24 in the United States. However, we must consider this statement in context. Relatively few young people die from cardiovascular disease, cancer and many other illnesses that contribute to mortality in older age strata. The two leading causes of death in AYA ages 15-24 in the US are accidents (unintentional injuries) and homicide (CDC 2018). Between 1999 and 2016, a total of 80,866 AYA in the US committed suicide, of whom 14,051 (17%) were female (CDC 2018). There is a significant disparity between the sexes in this proportion, which may be due to males using more lethal means (CDC 2014). Females more frequently report suicidal ideation and suicide attempts than do males (Nowotny 2015). In AYA of both sexes ages 15-24 in the 1999-2016 period, the overall rate of completed suicide was around 10.6 per 100,000 suicides (CDC 2018). Corresponding to their proportions, rates for

females and males respectively ages 15-24 were 3.8 and 17.1 per 100,000 suicides across the 1999-2016 period (CDC 2018).

Paradox. Let's look for a moment back to 1950, when gender roles, sex-specific dress codes, laws regulating sexuality and other aspects of social control were much more rigidly "enforced." The suicide rate for AYA in the US was much lower than it is now. For both sexes, it was only 4.5 suicides per 100,000 AYA. As is usual, the rate for boys was higher than that of girls, 6.5 vs. 2.6. From that year, through our society's *sturm und drang [rousing action and high emotionalism, turmoil]* of the '60s and '70s, AYA suicides trended upward, reaching a peak in 1994 with a combined rate of 13.6. The overall trend declined slightly and then was more or less flat until 2011, when it began again to climb.



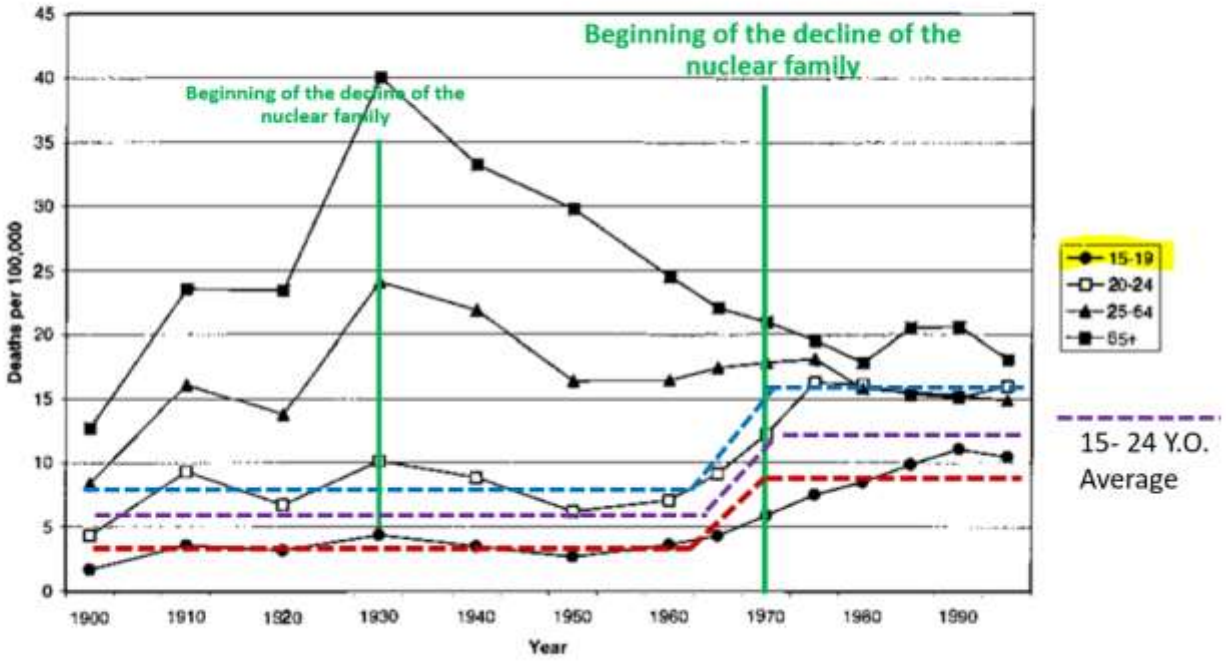


Fig. 5.2 Suicide rates by age over time

A problem emerges. Why have rates of completed suicide in AYA increased in recent years, during an era when public awareness of transgenderism and GD has increased dramatically? Not just "awareness" – by 2018, organizations and individual people make bizarrely intense efforts to seem the most supportive "trans ally." Other populations with elevated suicide rates include people with mood disorders or other mental illness (Nock 2013) and people who are sexually attracted to others of the same sex (Hottes 2016). These populations would likely also have experienced the earlier times with much greater distress than they would today. If the trans industry's logic were consistent, they would also have had higher rates of suicide. Were young people more psychologically stable and resilient in the old days than they are now?

Taking that trans logic a step further, why don't we see epidemics of suicide in populations that really have to deal with systemic bias? Are AYA-GD frequently pulled over by the police, frisked and hassled more than other AYA? Are they followed around in grocery stores and department stores more than other AYA? On rainy or sunny days, are their waving hands regularly ignored by taxicab drivers with empty cars, who then stop to pick up other AYA?

Although AYA-GD are relatively few in number, so too are the numbers of AYA completed suicides. If society now cranks out transphobia at lower levels than before, and if it were true that transphobia-induced dysphoria leads to suicide in AYA-GD, we would have expected to see very high rates of completed suicide in earlier decades. We should have seen these rates decline, if only a little. However, after warbling up and down for a few decades, they went up.

The relationship of "regret" to study attrition and possibly to suicide

Before finishing this article, I want to point out something explicitly. Long-term follow-up studies have shown that completed suicide rates in people who received trans hormones and surgeries, and supposedly "transitioned," are in fact much higher than in the general population (Asscheman 2011, Dhejne 2011, among

others). Few follow-up studies assess "regret" in their study populations. Those that do assess regret may also have very narrow criteria for defining "regret," or will follow-up after too short a time for patients to realize their regret. No-one really knows the right interval, but assessments of regret after three or five years are of limited value. Regret should still be assessed at such intervals, but those rates may not indicate the proportion of patients with regret at 10 or 15 years, particularly if there is high loss to follow-up. Loss to follow-up is generally judged to be high when it exceeds 20% (Higgins 2011).

Investigators often report very low regret rates. Consider that the feelings of regret one might experience in this context may be very deep and complex. It may seem pointless to change one's paperwork or to inform the doctor. At the same time, many of these studies have exceptionally high losses to follow-up; either they can't find these patients or they get no responses from them. On a personal level, I can tell you that I had zero interest in explaining my situation to anyone, and I never wanted to see a doctor again. Paperwork was the last thing on my mind. I only wanted to melt into the Earth.

Although I "detransitioned" (i.e. ceased trying to make people think I was a woman), it's important to bear in mind that "regret" and "detransition" are not synonymous. A person may experience profound regret but not feel prepared to "detransition," a very intense, emotionally painful and often frightening process.

And where did all those "lost" people go? They need medication for the rest of their lives. Are the ones in Wiepjes 2018, for example, lost somewhere in the Netherlands? How does that happen in a high-tech society? Other areas of medicine at least try to keep good patient follow-up, even in countries with few resources. I just wanted to suggest that some of these "lost" may in fact have expressed "regret" through intentionally losing their lives. Some may have quietly "detransitioned," but those not taking testosterone or estrogen would be living in increasingly poor health. Others may have continued in their "transsexual" status –but regretting what they had done.

There has been no peer-reviewed research into this – only happy stories about "tiny" regret rates. It is remarkable that individual stories in YouTube videos, blogs and books, as well as newspaper articles and other journalistic accounts, provide the best available evidence about regret. Zucker and colleagues (2016) usefully examine the report of Dhejne and colleagues (2014), in which "regret" data for Sweden are reported in patients receiving "sex re-assignment surgery" (SRS) between 1960 and 2010.

This paper suggests a regret rate of 2.2%, based on a very narrow criterion: formal application to the government to restore their original sex designation. Zucker and colleagues (2016) note that with a median follow-up of eight years, more recent regret may not yet have emerged, and then draw from Dhejne's earlier (2011) paper on health, suicidality and criminality outcomes in the Swedish transsexual population to show why a 2.2% regret rate is likely a gross underestimate.

Zucker and colleagues (2016) point out that while 10 of 666 (1.5%) of patients receiving SRS between 1972 and 2010 made formal regret applications, 10 of 324 (3.1%) who received SRS between 1973 and 2003 had killed themselves (Dhejne 2011, Zucker 2016). Another 29 of 324 (8.9%) receiving SRS in that period had made documented suicide attempts (Dhejne 2011, Zucker 2016).

If anyone wishes to suggest that this was all in the transphobic bad old days, I would remind them of the title of Hoenig's 1977 paper: "The legal position of the transsexual: mostly unsatisfactory outside Sweden" (Hoenig 1977). In other words, Sweden had a very liberal and accepting society.

What's clear is that there is currently a strange desire in the ideology and culture of transgenderism to ruthlessly extirpate any evidence that contradicts the official narrative of "born this way." The fact is that

people with gender dysphoria really do have quite serious mental health issues that for the most part are either ignored or celebrated. The existence of "regret" and detransition is a huge thorn in their side, a threat to their "validity." This may be the reason that few studies bother to assess regret; or even keep good track of their patients, as is done in other areas of medicine that commonly maintain patients in long-term chronic disease care.

It's not right to ignore evidence of suicides or imply that those lost to follow-up are probably just living happily ever after. This is how researchers can create the impression that regret rates are low. Some investigators assess regret after too short an interval, such as the "less than one year" (and possibly as little as two weeks) to five years for radical mastectomy in young women age 13-25, reported in Olson-Kennedy 2018. But is Dhejne's 2.2% really a low proportion? If you were keen to skydive, and you learned that 2.2% of parachutes didn't open – would you jump?

Table: Losses to follow-up (Partial, incomplete list of studies)

Study	Country	Follow-up	Lost to follow-up
De Cuypere 2006	Belgium	MtF mean 4.1 yr FtM mean 7.6 yr	28%
Hepp 2002	Switzerland	67 mo (19-114 mo)	30%
Kaube 1991	Germany	3-6 yr (0.8-11 yr)	53%
Rauchfleisch 1998	Germany	MtF mean 14 yr FtM mean 9.5 yr	75%
Revol 2006	France	10 yr	65%
Smith 2005	Netherlands	1-4 yr	33%
van de Grift 2018	NL, BE, DE	4-6 years	63%
Wiepjes 2018	Netherlands	6.4 yr (0.4 yr-41.6 yr)	36%

Table: Reported regret and criteria for regret (Partial, incomplete list of studies)

Study	Country	Regret criteria	Regret	Lost to follow-up
Dhejne 2014	Sweden	Formal application to government to restore original sex marker	2.2%	n/a
Imbimbo 2009	Italy	Interview	6%	15%
Smith 2005	Netherlands	Interview	2.6%	33%
Van de Grift 2018	NL, BE, DE	Interview	6% (deemed "minor")	63%

Wiepjes 2018	Netherlands	Note in patient's medical record	0.5%	36%

4. Conclusion

In summary, the high estimates commonly bandied about by trans activists and the mass media in regard to suicide and suicide attempts in AYA-GD are likely much too high. Completed suicide and suicide attempt rates in the AYA-GD population may vary significantly by region and socio-economic context. In my opinion, however, they are likely to remain consistent (in a given setting) with those of other populations of which they are also constituents — sexual minority AYA populations, AYA who experience bullying and AYA living with other mental health problems.

The trans industry's insistence and hype that AYA-GD are constantly on the brink of transphobia-related suicide at rates that far exceed those of other highly relevant populations is a shameful social engineering strategy to keep society's focus preferentially on transgenderism–perhaps to cast themselves as visionary pioneers in the field. I don't think it will turn out that way for the clinicians: history will not absolve them.

As I mentioned earlier in this article, there have been no rigorous studies conducted (ever) of any psychological intervention to help AYA-GD (or anyone) to cope effectively with their GD and thereby become more comfortable in their bodies. I'm working on another paper on this topic, because it is very deep and rich and there is much to cover, but here are some preliminary thoughts.

There is absolutely no good reason why gender dysphoria has essentially been excluded from 15 years of research in new "transdiagnostic" approaches to treating people with depression and anxiety disorders. It is outrageous that no trials have been done of cognitive behavioural therapy, dialectical behavioural therapy, mindfulness therapy and other new approaches to reduce rumination, cognitive bias generation and other maladaptive coping that may be prodromal to or concurrent with the emergence of GD; as well as to treat patients currently experiencing the condition. GD is not *sui generis*, unique, super-special! It is well within the spectrum of conditions efficaciously treated with transdiagnostic approaches. It is as though the "transition" promoters of mainstream transgenderism had some kind of a racket going on.

[INSERT] Wikipedia (4-28-2023): (https://en.wikipedia.org/wiki/List_of_LGBT-related_suicides)-
A total of four (4) Transgender completed Suicides have been listed from 2009 to 2023 for the whole United States, with the average suicide age of 32 years old. For the whole world, Wikipedia lists a total 11 completed suicides from 2009 to 2023 (over a 24 year duration):

Anannyah	1993 – 20 July 2021	28	Kerala, India	T[1]
Leelah Alcorn	15 November 1997 – 28 December 2014	17	Kings Mills, Ohio, US	T[3]
Blake Brockington	15 May 1996 – 23 March 2015	18	Charlotte, North Carolina, US	T[14]
Eylül Cansın	1992 – 5 January 2015	23–24	Istanbul, Turkey	T[17]
Daphne Dorman	1975 – 11 October 2019	44	San Francisco, US	T[32]
Fouad	2003 – 18 December 2020	17	Lille, France	T[40]
Rebwar Ibrahimi	2002 – 8 February 2022	20	Marivan, Iran	T[55]
Felis Joy	2006 – 11 April 2022	16	Chișinău, Moldova	T[59]
Eden Knight	c. 2000– 12 March 2023	23	Saudi Arabia	T[63]
Sherin Celin Mathew	1996 – 17 May 2022	26	Kochi, India	T[71]
Mike Penner	10 October 1957 – 27 November 2009	52	Los Angeles, California, US	T[85]

Again, there has not been even one study that tested psychological interventions to alleviate GD symptoms, much less any of the new ones. Why not? Because Harry Benjamin declared it to be a "useless undertaking"! Sure, it may have been "hard to treat" using the arcane psychoanalytic or Kleinian object relations methods that used to be popular, but trans industry "hormones and surgery" dogma has kept anyone from testing the new methods.

When simple remedies are untried, it is not preferable to put healthy but confused patients on lifelong drug regimens and offer them drastic surgeries that do not accomplish what patients hope they will do and are often accompanied by significant complications.

If it is possible to help people with GD to cope with, and perhaps even recover from GD, using an inexpensive approach that is feasible to implement anywhere, this would surely be better than the extreme and lifelong medical interventions currently presented as the only alternative to a life of misery (or a life lost to suicide).

This piece is already long; I will more thoroughly explore the topic of alternative approaches to gender dysphoria in a future article.

Hacsi Horváth, MA, PgCert (Sheffield) in 2022:

Former Transgender Activist: Transitioning Is Dangerous—Especially For Youth

REFERENCES

1. Alastanos JN, Mullen S. Psychiatric admission in adolescent transgender patients: A case series. Mental Health Clinician. 2017;7:172-175
2. Asscheman H, Giltay EJ, Jos A J Megens, W (Pim) de Ronde, Michael A van Trotsenburg, Louis J G Gooren. A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. European Journal of Endocrinology. 2011;164:635-642.
3. Billings DB, Urban T. The Socio-Medical Construction of Transsexualism: An Interpretation and Critique. Social Problems. 1982;29:266-282.
4. Burchard JM. Psychopathology of Transvestism and Transsexualism. The Journal of Sex Research. 1965;1:39-43.
5. Byne W, Bradley SJ, Coleman E, et al. Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder. Archives of Sexual Behavior. 2012;41:759-796.
6. Centers for Disease Control and Prevention (CDC). Youth Risk Behavior Surveillance – United States, 2017. Morbidity and mortality weekly report. Surveillance summaries (Washington, D.C. : 2002). 2018;67:1-114.
7. Chiland C. Transsexualism: Illusion and Reality. Middletown: Wesleyan University Press, 2003.
8. Connolly MD, Zervos MJ, Barone CJ, Johnson CC, Joseph CLM. The Mental Health of Transgender Youth: Advances in Understanding. Journal of Adolescent Health. 2016;59:489-495
9. Costa R, Carmichael P, Colizzi M. To treat or not to treat: puberty suppression in childhood-onset gender dysphoria. Nature reviews. Urology. 2016;13:456-462.
10. Crowell SE, Skidmore CR, Rau HK, Williams PG. "Psychosocial Stress, Emotion Regulation, and Resilience in Adolescence." In: O'Donohue WT et al. (eds.), Handbook of Adolescent Health Psychology. DOI 10.1007/978-1-4614-6633-8_9, © Springer Science+Business Media, New York, 2013
11. Dhejne C, Lichtenstein P, Boman M, Johansson AL, Långström N, Landén M. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. PLoS One. 2011 Feb 22;6(2):e16885.
12. Dhejne C, Öberg K, Arver S, Landén M. An analysis of all applications for sex reassignment surgery in Sweden, 1960-2010: prevalence, incidence, and regrets. Arch Sex Behav. 2014 Nov;43(8):1535-45.
13. Duišin D, Batinić B, Barišić J, Djordjevic ML, Vujović S, Bizic M. Personality disorders in persons with gender identity disorder. ScientificWorldJournal. 2014;2014:809058.
14. Gideon L, ed. Handbook of Survey Methodology for the Social Sciences. New York: Springer: 2012

15. Gijs L, Brewaeys A. Surgical Treatment of Gender Dysphoria in Adults and Adolescents: Recent Developments, Effectiveness, and Challenges. Annual Review of Sex Research. 2007;18:178.
16. Gili M, Castellví P, Vives M, et al. Mental disorders as risk factors for suicidal behavior in young people: A meta-analysis and systematic review of longitudinal studies. Journal of Affective Disorders. 2019;245:152-162.
17. Grant JM, Mottet LA, Tanis J, Harrison J, Herman JL, Keisling M (2011). Injustice at Every Turn: A Report of the National Transgender Discrimination Survey. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force. Available: http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf
18. Haas AP, Rodgers PL, Herman JL (2014). Suicide Attempts among Transgender and Gender Non-Conforming Adults. The Williams Institute, University of California, Los Angeles. Available: https://williamsinstitute.law.ucla.edu/category/research/transgender-issues
19. Heckathorn DD, Cameron CJ. Network Sampling: From Snowball and Multiplicity to Respondent-Driven Sampling. Annual Review of Sociology. 2017;43:101-119.
20. Hepp U, Kraemer B, Schnyder U, Miller N, Delsignore A. Psychiatric comorbidity in gender identity disorder. Journal of Psychosomatic Research. 2005;58:259-261.
21. Herman JL, Wilson BD, Becker T. Demographic and Health Characteristics of Transgender Adults in California: Findings from the 2015-2016 California Health Interview Survey. Policy Brief. UCLA Cent Health Policy Res. 2017 Oct;(8):1-10.
22. Heylens G, Elaut E, Kreukels BPC, et al. Psychiatric characteristics in transsexual individuals: multicentre study in four European countries. British journal of psychiatry. 2014;204:151-156.
23. Hoenig J, Kenna JC. The nosological position of transsexualism. Arch Sex Behav. 1974 May;3(3):273-87
24. Hoenig J. The legal position of the transsexual: mostly unsatisfactory outside Sweden. Can Med Assoc J. 1977 Feb 5;116(3):319-23.
25. Hottes TS, Bogaert L, Rhodes AE, Brennan DJ, Gesink D. Lifetime Prevalence of Suicide Attempts Among Sexual Minority Adults by Study Sampling Strategies: A Systematic Review and Meta-Analysis. American journal of public health. 2016;106:e1-e12.
26. Husky MM, Olfson M, He JP, Nock MK, Swanson SA, Merikangas KR. Twelve-month suicidal symptoms and use of services among adolescents: results from the National Comorbidity Survey. Psychiatr Serv. 2012 Oct;63(10):989-96.
27. James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.
28. Kaltiala-Heino R, Bergman H, Työläjärvi M, Frisén L. Gender dysphoria in adolescence: current perspectives. Adolescent health, medicine and therapeutics. 2018;9:31-41.
29. Kennebeck S, Bonin L. Suicidal behavior in children and adolescents: Epidemiology and risk factors. "UptoDate" [online database]. Last updated 21 November 2017. Accessed 5 November 2018
30. Levine SB. Ethical Concerns About Emerging Treatment Paradigms for Gender Dysphoria. Journal of Sex & Marital Therapy. 2018;44:29-44.
31. Liotta M, Mento C, Settineri S. Seriousness and lethality of attempted suicide: A systematic review. Aggression and Violent Behavior. 2015;21:97-109.
32. Littman L. Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports. PloS one. 2018;13:e0202330.
33. Lothstein LM. Psychological testing with transsexuals: a 30-year review. Journal of Personality Assessment. 1984;48:500.
34. Lowry R, Johns MM, Gordon AR, Austin SB, Robin LE, Kann LK. Nonconforming Gender Expression and Associated Mental Distress and Substance Use Among High School Students. JAMA Pediatrics. 2018.
35. Messias E, Kindrick K, Castro J. School bullying, cyberbullying, or both: Correlates of teen suicidality in the 2011 CDC youth risk behavior survey. Comprehensive Psychiatry. 2014;55:1063-1068.

36. Nock MK, Green JG, Hwang I, McLaughlin KA, Sampson NA, Zaslavsky AM, Kessler RC. Prevalence, correlates, and treatment of lifetime suicidal behavior among adolescents: results from the National Comorbidity Survey Replication Adolescent Supplement. JAMA Psychiatry. 2013 Mar;70(3):300-10.
37. Nowotny KM, Peterson RL, Boardman JD. Gendered Contexts: Variation in Suicidal Ideation by Female and Male Youth across U.S. States. Journal of Health and Social Behavior. 2015;56:114-130.
38. Olson-Kennedy J, Warus J, Okonta V, Belzer M, Clark LF. Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts. JAMA Pediatrics. 2018;172:431-436.
39. Pauly IB. Male Psychosexual Inversion: Transsexualism: A Review of 100 Cases. Archives of General Psychiatry. 1965;13:172-181.
40. Raymond J. The Transsexual Empire: The Making of the She-Male. Boston: Beacon Press, 1979
41. Reisner SL, Biello KB, White Hughto JM, et al. Psychiatric Diagnoses and Comorbidities in a Diverse, Multicity Cohort of Young Transgender Women: Baseline Findings from Project LifeSkills. JAMA Pediatrics. 2016;170:481-486.
42. Ristori J, Steensma TD. Gender dysphoria in childhood. International review of psychiatry (Abingdon, England). 2016;28:13-20.
43. Sarchiapone M, D'Aulerio M, Iosue M. "Suicidal Ideation, Suicide Attempts and Completed Suicide in Adolescents: Neurobiological Aspects." In: Kaschka WP, Rujescu D (eds). Biological Aspects of Suicidal Behavior. Basel, Karger, 2016
44. Stone DM, Luo F, Ouyang L, Lippy C, Hertz MF, Crosby AE. Sexual orientation and suicide ideation, plans, attempts, and medically serious attempts: evidence from local Youth Risk Behavior Surveys, 2001-2009. American journal of public health. 2014;104:262-271.
45. Strosahl KD, Chiles JA. Suicidal and self-destructive behavior. In: Fisher JE and O'Donohue WT (eds). Practitioner's guide to evidence-based psychotherapy. New York: Springer, 2006.
46. Toomey RB, Syvertsen AK, Shramko M (2018). Transgender Adolescent Suicide Behavior. Pediatrics. 2018;142(4): e20174218
47. van de Grift TC, Elaut E, Cerwenka SC, Cohen-Kettenis PT, Kreukels BPC. Surgical Satisfaction, Quality of Life, and Their Association After Gender-Affirming Surgery: A Follow-up Study. J Sex Marital Ther. 2018 Feb 17;44(2):138-148.
48. Wiepjes CM, Nota NM, de Blok, Christel J M, et al. The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets. The journal of sexual medicine. 2018;15:582.
49. Wilson B, Choi SK, Herman JL et al. Characteristics and mental health of gender-non-conforming adolescents in California. UCLA Center for Health Policy Research and The Williams Institute. Los Angeles: 2017. Available: https://williamsinstitute.law.ucla.edu/wp-content/uploads/CHIS-Transgender-Teens-FINAL.pdf
50. Wise J. High rates of psychiatric diagnoses are found in young transgender women. BMJ. 2016;352.
51. Zucker KJ, Lawrence AA, Kreukels BP. Gender Dysphoria in Adults. Annu Rev Clin Psychol. 2016;12:217-47.
52. Zucker KJ. Epidemiology of gender dysphoria and transgender identity. Sex Health. 2017 Oct;14(5):404-411.