CHLOE COLE

PUBLIC WEBSITE EDITION

YOUR BODY IS NOT A MISTAKE

Evidence, answers, and support for families facing gender distress

> **"I was not a boy. I was a girl in distress."**
>
> Chloe Cole, testimony to the U.S. Senate HELP Committee, 2026
>
> **No child is born in the wrong body.**

Research cutoff: July 19, 2026

Version 2.0

ABOUT THIS GUIDE

About this guide

This guide is written for parents, young people, detransitioners, clinicians, journalists, policymakers, and anyone seeking clear answers about pediatric gender medicine. It combines Chloe Cole's convictions and lived experience with a documented review of the evidence.

DIGNITY AND TRUTH

This guide argues that no child is born in the wrong body and that medical transition for minors should end. It criticizes a treatment model, institutional claims, and public policy, not the human worth of any person. Every person deserves dignity, safety, ordinary healthcare, and freedom from threats or harassment.

MEDICAL SAFETY

Do not abruptly stop prescribed hormones or other medication because of this guide. A person considering discontinuation should speak with an appropriately licensed clinician, especially after removal of gonads. Call 911 or go to an emergency department for immediate danger, a suicide attempt in progress, severe surgical complications, chest pain, shortness of breath, uncontrolled bleeding, or other urgent symptoms. In the United States, call or text 988 for crisis support. [70, 81, 82]

Purpose and scope

- The guide reviews social transition, puberty blockers, cross-sex hormones, surgery, informed consent, international policy, parental responsibility, and practical support.
- It is not individualized medical or legal advice, a clinical practice guideline, or a substitute for a licensed professional who knows the patient.
- Research cutoff: July 19, 2026. Laws, court orders, clinical policies, and service rules can change; verify the current position in the relevant jurisdiction.
- Bracketed numbers refer to the references at the end of the guide.

The strongest argument is not built on exaggeration. It is built on a simple principle: when medicine proposes to interrupt healthy sexual development, alter secondary sex characteristics, impair or end fertility, or remove healthy tissue from a minor, the burden of proof should be exceptionally high. The current evidence does not meet that burden.

FOREWORD

A message from Chloe

IN CHLOE'S WORDS

"I was not a boy. I was a girl in distress." [88]

I know what it is like to be a child who feels alienated from her body. I also know what happens when adults turn that distress into a medical identity and then treat a healthy body as the disease. I was given puberty blockers, testosterone, and a double mastectomy before I was old enough to understand what motherhood, sexual function, fertility, or a lifetime of medical consequences could mean.

The adults around me were offered a false choice. My parents were told that transition was the path to safety and that refusing could place my life at risk. They were not given a fair explanation of uncertainty, alternatives, long-term follow-up, or the possibility that my feelings could change. They loved me. The system used that love and fear to push them toward permanent decisions.

No child is born in the wrong body. A child can feel intense distress, confusion, shame, discomfort, or fear. Those feelings are real. But the body is not a mistake, and medicine cannot turn a girl into a boy or a boy into a girl. It can suppress development, create an approximation of opposite-sex traits, or remove healthy organs and tissue. Calling that affirmation does not change what it does.

This guide is direct because children need adults who are willing to tell the truth. I believe medical transition is damaging by design. Its intended mechanism interferes with healthy bodily function or anatomy. Psychological responses vary, and some patients report relief, but relief is not proof of net lifelong benefit. Teaching a child to regard the sexed body as the enemy is, in my judgment, a profound psychological wrong even when that message is delivered with kindness.

Parents should not be sidelined by a medical-industrial system that presents contested claims as settled science. Doctors can offer technical knowledge. Fit parents usually know their child's history, character, vulnerabilities, values, and needs better than any clinic. The law has long recognized a presumption that fit parents act in their children's best interests, while preserving safeguards for abuse, neglect, and genuine emergencies. [100, 101]

I use the word **scam** for the gender-affirming care model because its public sales pitch is not honest about what is being purchased. The language promises authenticity, reversibility, safety, and suicide prevention. The evidence is uncertain, some physical effects are irreversible, long-term outcomes are poorly tracked, and the pathway can close a child's future options. This is a judgment about a system and its claims, not an allegation that every clinician commits criminal fraud or intends harm.

The goal is not to win an argument. It is to keep another child from living with a preventable loss. Young people in distress need truth, time, family, careful mental-health care, protection from bullying, treatment of other conditions, and hope that they can grow into peace with the body they already have.

Chloe Cole

Detransitioner and Patient Advocate

START HERE

Seven convictions at the center of this guide

These are Chloe's conclusions. The sections that follow distinguish biological facts, evidence findings, ethical judgments, and policy positions.

1	**Your body is not a mistake.** A child may experience genuine distress about sex or puberty, but distress does not prove that the body is wrong or that the child was born as the opposite sex. [53, 54, 88]
2	**Sex is real and cannot be medically changed.** Medicine can alter appearance, hormones, and anatomy. It cannot change the body's underlying reproductive organization from male to female or female to male. [53, 54]
3	**Medical transition is bodily harm by design.** Puberty suppression interrupts healthy development, cross-sex hormones impose non-native sex traits, and surgery removes or reshapes healthy tissue. These are intended mechanisms, not rare side effects. [2, 3, 8-12, 17, 34-36, 81, 89, 93-97]
4	**Psychological distress deserves care, not bodily destruction.** Mental-health symptoms, trauma, autism, OCD, eating disorders, body image, sexuality, family conflict, and social pressure should be assessed without assuming that transition is the answer. [1, 4-7, 15, 38, 92]
5	**Children cannot carry adult medical consequences.** Minors can describe their feelings and should be heard. They cannot reliably understand the full meaning of infertility, sexual dysfunction, altered anatomy, lifelong monitoring, or regret decades later. [17, 24, 48, 49, 88]

6	**Fit parents are the primary protectors of their children.** Clinicians advise, but parents generally know the whole child better than a clinic does. Parental authority is not absolute, yet it should not be displaced by fear-based claims or institutional pressure. [88, 100, 101]
7	**Every outcome deserves care and honest tracking.** A responsible system must follow patients who continue, stop, regret, or detransition. Detransitioners should receive competent medical and psychological aftercare without ideological conditions. [42-46, 62, 74-79, 98]

EXECUTIVE SUMMARY

What the evidence shows

CORE MESSAGE

Young people in distress deserve help now. The disputed question is whether current evidence justifies interventions that suppress healthy puberty, alter sexual development and fertility, or remove healthy tissue before adult maturity. Repeated reviews find the evidence for key psychosocial benefits low, very low, or otherwise too uncertain for confident causal and long-term conclusions. Chloe's position is that minors should not be medically transitioned. [1-13, 24, 89-103]

- **Gender dysphoria can be severe.** A cautious model must offer timely mental-health care, family support, protection from bullying, and treatment for co-occurring conditions.
- **No study can establish that a child was born in the wrong body.** That phrase is a metaphysical interpretation, not a medical finding.
- **Systematic reviews repeatedly find weak certainty for key benefits.** The defensible formulation is low or very-low certainty, not "zero evidence" and not "proven effective."
- **Physical effects are not speculative.** Blockers suppress puberty, hormones change sex characteristics, and surgery permanently alters anatomy. Some effects are irreversible and fertility can be impaired.
- **Puberty blockers are not a neutral pause.** Puberty usually resumes after stopping, but bone accrual is affected and the full reproductive, sexual, and neurodevelopmental consequences of treatment timing and sequencing remain uncertain.
- **Hormone studies contain benefit signals, but causality is weak.** Prospective cohorts report improvements in appearance congruence and some mental-health measures, yet selection, concurrent care, expectations, attrition, and lack of untreated comparators limit inference.
- **There is no reliable evidence that pediatric medical transition prevents suicide death.** Ideation, self-harm, attempts, and verified deaths are different outcomes.
- **Surgery on minors is uncommon but documented.** Most identified procedures are chest surgeries. Rare does not mean never.
- **Social transition is a meaningful intervention.** It changes family, school, peer, and identity expectations. Long-term causal benefits and harms are not established.
- **Detransition and regret rates are not known precisely.** Definitions, follow-up, loss to follow-up, intervention type, and sampling prevent one universal percentage.
- **International policy is contested.** Several countries have moved toward psychosocial-first, centralized, exceptional-case, research-only, or restricted models, while major U.S. organizations still support selected access.
- **Policy is an ethical judgment under uncertainty.** Chloe argues that when the intervention is elective, development-altering, and partly irreversible, uncertainty should protect the child's body and future rather than justify experimentation.

ANSWERS

Eight questions readers ask first

Is this guide anti-trans?

No. It opposes pediatric transition and rejects the idea that a healthy body is a mistake. It also rejects ridicule, threats, dehumanization, and denial of ordinary healthcare.

Are children making it up?

Not necessarily. Distress can be sincere and severe. Sincerity does not prove that a child is the opposite sex or that medical transition will produce net lifelong benefit.

Can medicine change sex?

No. Medicine can change hormones, appearance, and anatomy. It cannot reorganize a human body from the male reproductive type into the female type or the reverse.

Are blockers reversible?

Pubertal progression generally resumes after discontinuation, but "fully reversible" overstates what is known about bone, fertility pathways, sexual development, and neuropsychology.

Does transition prevent suicide?

Current research does not establish prevention of suicide death. Acute risk requires standard suicide assessment and treatment, not a rushed irreversible-consent process.

Is regret only 1 percent?

No single rate applies across ages, treatments, definitions, follow-up periods, and loss to follow-up. Some cohorts report low measured regret, but lifetime youth outcomes remain uncertain.

Do all medical groups agree?

No. Several U.S. bodies support access, while official reviews and policies in other countries have become substantially more cautious. Guideline endorsement is not the same as high-certainty evidence.

What should a parent do now?

Lead with love, stabilize safety and daily function, gather records, request comprehensive assessment, ask for absolute-risk evidence, and seek a second opinion before any irreversible step.

PART I

What medical transition actually does

The phrase "gender-affirming care" bundles very different interventions under a reassuring label. This section describes the mechanisms before debating outcomes.

1. Sex, body, and the claim of a "wrong body"

Human sex is a binary reproductive classification organized around two gamete types, ova and sperm. A person need not be fertile, mature, or currently producing gametes to be male or female. Differences of sex development are medically important variations within male or female development; they do not create additional reproductive classes. [53, 54]

Gender dysphoria is distress related to sex or perceived gender incongruence. It describes an experience of distress. It does not prove that the body is incorrectly sexed, that a hidden opposite-sex self exists inside the body, or that altering the body is the best treatment. The sentence "born in the wrong body" is a philosophical and moral interpretation, not a laboratory result.

CHLOE'S CONVICTION

No child is born in the wrong body. The child is not the error. The body is not the diagnosis. The duty of adults is to help a distressed child live truthfully and safely in the body he or she has, not to teach that health requires escaping it.

This biological definition does not answer every legal, social, linguistic, or pastoral question. It does establish one limit: medical transition can alter traits, suppress functions, and remove tissue, but it cannot change sex. That fact can be stated plainly while treating every person with courtesy and dignity.

2. Social transition

Social transition can include a new name, pronouns, clothing, role, school records, restroom arrangements, or public declaration of a new identity. It does not directly alter tissue, but it is not psychologically neutral. It can change how a child interprets discomfort, how adults respond, and what family and peers expect. Reversing it may become socially costly or humiliating. [5, 31]

The York review found too little evidence to establish overall benefit, harm, or a causal effect on identity persistence. The Olson cohort found high identity stability among children who had already socially transitioned, but the design cannot show that social transition caused persistence or that the result applies to all questioning children. [5, 31]

PRACTICAL RULE

Do not turn a child's uncertainty into a public identity project. Keep choices private, flexible, age-appropriate, and easy to revise. Protect the child from bullying without demanding that everyone participate in a claim about sex.

3. Puberty suppression

Gonadotropin-releasing hormone analogues suppress the hormonal signals that drive puberty. The intended effect is to interrupt normal pubertal development while medication is administered. Use in central precocious puberty provides useful safety information, but the gender-dysphoria pathway differs in age, treatment goal, duration, baseline mental health, and frequent progression to cross-sex hormones. [2, 8, 10, 80, 89]

Question	Answer
What is established	Pubertal progression is suppressed while treatment continues. Bone accrual relative to age expectations is affected. Growth, body composition, and sex-characteristic development change.
What is often claimed	That blockers are a neutral pause, fully reversible, and independently improve mental health or prevent suicide.
What remains uncertain	Long-term peak bone mass and fractures, fertility across the blocker-to-hormone pathway, sexual function, neurodevelopment, and independent psychosocial benefit.
Evidence status	York, NICE, McMaster, BMA, SBU, and other reviews find the critical outcome evidence low, very low, or insufficient for confident causal conclusions.

Bone density z-scores commonly decline during suppression. Recovery after subsequent hormones varies by site and regimen. Some long-term data show substantial recovery, while lumbar-spine measures in participants receiving estrogen may remain lower than baseline expectations. These findings do not prove that every patient will suffer osteoporosis, but they rule out describing the pathway as physically consequence-free. [34, 35, 89, 93-95]

BOTTOM LINE

Calling puberty blockers a "pause button" hides the central fact: the treatment suppresses a healthy developmental process during a period that cannot be replayed. Puberty generally resumes after stopping, but the whole pathway cannot be described as fully reversible. **[2, 8-10, 34-36, 80, 89, 93-95]**

4. Masculinizing and feminizing hormones

Testosterone and estrogen-based regimens induce selected secondary sex characteristics of the opposite sex. Some changes are irreversible or only partly reversible. Testosterone can permanently deepen the voice and enlarge the clitoris; estrogen can produce breast development. Other effects may include altered body composition, hair patterns, skin, menstruation or sperm production, blood counts, lipids, blood pressure, and fertility. Monitoring requirements differ by regimen and patient. [3, 11, 25, 81]

Dimension	What readers should know
Physical goal	Create an approximation of opposite-sex secondary traits while suppressing or overriding native sex development.
Potentially permanent effects	Voice deepening, breast development, genital changes, some hair-pattern changes, and fertility consequences that may not fully recover.
Evidence for psychosocial benefit	Some cohorts show improved appearance congruence, depression, anxiety, or functioning. Systematic reviews judge most youth-specific causal estimates low or very low certainty.
Long-term unknowns	Fertility, sexual function, cardiometabolic outcomes over decades, interaction with earlier blockers, and who benefits or later changes goals.

Chen and colleagues followed 315 participants aged 12 to 20 for two years after starting hormones and reported favorable changes in appearance congruence and several psychosocial measures. This is meaningful supportive evidence. It was also a single-arm cohort from specialized clinics, so it cannot separate treatment effects from

maturation, concurrent therapy, family support, expectations, selection, regression to the mean, or other confounding. [29]

Off-label prescribing is common in medicine and is not automatically improper. It also does not answer whether a particular indication has favorable long-term benefit for minors. The relevant questions remain evidence, consent, alternatives, monitoring, and the cost of error. [8, 25]

5. Surgery

Gender-related surgery permanently removes, reshapes, or constructs anatomy. In minors, claims data indicate that identified procedures are uncommon at the population level and are predominantly chest surgeries. Exact totals are limited by coding, indication, insurance coverage, and unobserved cash-pay care. "Uncommon" is accurate. "Never" is false. [17, 40, 41, 64, 86]

Procedure area	Core reality
Chest surgery	Permanent removal or reshaping of breast tissue. Risks include scarring, altered sensation, pain, asymmetry, revision, and loss of breastfeeding capacity.
Genital surgery	Permanent alteration of reproductive and sexual anatomy with ordinary and procedure-specific surgical risks. Minor-specific evidence is extremely limited.
Facial surgery	Permanent skeletal or soft-tissue alteration. Evidence specific to minors and long-term psychosocial outcomes is limited.
Evidence status	A 2025 review found very-low certainty evidence for psychological outcomes after mastectomy in people under 26. Complication estimates largely came from uncontrolled case series and mixed age groups.

In 2026, the American Society of Plastic Surgeons published a position statement addressing breast/chest, genital, and facial gender surgery for people under 19. The statement recommends delay to at least 19 on the basis of insufficient evidence of a favorable risk-benefit ratio for minors, while noting that the position is not itself a legal standard of care. [17]

CHLOE'S POSITION

Removing or reshaping healthy tissue to resolve psychological distress is not neutral care. The operation may be competently performed and the patient may report satisfaction, yet the body has still been permanently injured in pursuit of an identity claim medicine cannot make biologically true.

6. The pathway matters more than any single step

Public debate often isolates one intervention: a name change, then blockers, then hormones, then surgery. Families experience a pathway. Each step can change expectations and make the next step seem like confirmation of the last. Evidence from one indication, one stage, or one short follow-up cannot be used to prove the net benefit of the entire sequence.

The most consequential uncertainty concerns sequencing. A child whose puberty is suppressed and who then begins cross-sex hormones may never experience typical endogenous puberty. That affects the meaning of claims about reversibility, fertility, sexual development, and future choice. [9, 10, 34-36, 80, 89, 93-97]

PART II

What the evidence shows, and what it cannot show

This section explains why apparently impressive studies can still be unable to answer the question a family actually faces.

7. Evidence hierarchy

Level	Source type	Best use	Main caution
A	Systematic reviews and official evidence assessments	Overall certainty, research gaps, consistency, and direction	Different reviews may frame questions differently. Read inclusion rules and grading methods.
B	Prospective or comparative cohort studies	Outcome signals, trajectories, and effect estimates	Selection, confounding, attrition, missing data, and weak comparators can block causal inference.
C	Clinical guidelines and official policies	Current practice, commissioning, and policy choices	Recommendations combine evidence with values. Endorsement does not raise the certainty of the underlying studies.
D	Ethics, methods, and narrative reviews	Consent, conceptual analysis, hypotheses, and critique	Author perspective matters. Do not call commentary a systematic review.
E	Journalism, advocacy, and testimony	Documents, institutional history, lived experience, and public argument	Useful as leads or proof that an outcome is possible, not as prevalence or treatment-effect evidence.

When a review says **low certainty**, the true effect may be substantially different from the estimate. **Very-low certainty** means it is likely to be substantially different. Neither phrase means "proven ineffective." It means the evidence cannot support confident promises about magnitude, durability, or net benefit. [10, 11, 13]

WHY UNCERTAINTY MATTERS MORE HERE

Low certainty occurs in many areas of medicine. The ethical response depends on severity, alternatives, reversibility, developmental capacity, known and plausible harms, and the cost of a mistaken decision. The burden should be higher when an elective intervention permanently changes a minor's sexual development, fertility, or anatomy. [9, 13, 17, 24]

8. The population changed

Gender-clinic referrals rose rapidly, with a major shift toward adolescent females and frequent co-occurring mental-health or neurodevelopmental needs. The Cass and York work emphasize that this is a heterogeneous population that requires whole-child assessment rather than a single predetermined pathway. [1, 6, 7, 15]

Autism is overrepresented in gender-referred populations. A meta-analysis estimated an autism diagnosis prevalence of about 11 percent, with substantial heterogeneity. This association justifies adapted communication and assessment. It does not prove that autism causes transgender identification or that every autistic young person is mistaken. [38]

Other clinically relevant factors can include depression, anxiety, OCD, trauma, eating disorders, body image, sexuality, family conflict, bullying, online immersion, and ordinary adolescent development. None provides a universal explanation. The error is not considering them carefully before treating the body as the problem.

COMPLEXITY REQUIRES MORE CARE, NOT LESS COMPASSION

A comprehensive assessment is not a search for a convenient excuse to dismiss a child. It is the ordinary duty to understand the whole person before making a permanent decision.

9. Natural history and prediction

Older childhood-clinic studies found that many children no longer met earlier diagnostic criteria at follow-up. Those cohorts differ from current adolescent referrals in age, sex ratio, definitions, treatment exposure, and social context. A universal claim that 80 or 85 percent of today's adolescents will desist is not defensible. [39]

At the other end, the Olson early-social-transition cohort showed substantial identity stability over about five years. That finding is real, but it does not show that social transition caused persistence or that every questioning child follows the same trajectory. [31]

No validated tool predicts with high accuracy which young person will persist, desist, stop treatment, detransition, or regret intervention. This uncertainty strengthens the case for time, staged decisions, and preservation of future options. It does not support promising that every child will simply grow out of distress. [1, 31, 39, 92]

10. Mental health, self-harm, and suicide

Gender-distressed youth can have elevated rates of depression, anxiety, self-harm, and suicidal thoughts. Those risks are real and must be treated seriously. But suicidal ideation on a survey, a composite measure of ideation or self-harm, a reported attempt, and verified suicide death are different outcomes. A claim that treatment prevents suicide requires far stronger evidence than a short-term association with a questionnaire score. [29, 30, 37]

Tordoff and colleagues followed 104 clinic patients for one year. Receipt of blockers or hormones was associated with lower odds of depression and a composite self-harm or suicidal-thought outcome. The study was nonrandomized, combined treatments, did not capture some medication data, had selection and attrition concerns, and did not measure suicide death. The authors did not claim causation. [30]

A Finnish register study found few suicide deaths. After adjustment for specialist psychiatric treatment history, mortality differences were not statistically significant. That supports direct treatment of psychiatric illness, but rare events, wide intervals, and observational design prevent a universal conclusion about treatment effects in either direction. [37]

NEVER USE "TRANSITION OR DIE"

A suicide threat is a reason for immediate, standard safety assessment. It is not a reason to compress an irreversible-consent process. Ask about intent, plan, means, and timing; reduce access to lethal means when possible; use 988; and call 911 for immediate danger. No family should be coerced by an unsupported guarantee that a specific elective intervention will prevent death. [30, 37, 70]

11. Detransition, discontinuation, and regret

There is no single trustworthy detransition percentage. Studies define the outcome differently: stopping medication, changing identity, reversing social steps, seeking reversal surgery, regretting treatment, or changing goals. Clinics may lose patients to follow-up, while online surveys may over-recruit dissatisfied people. Treatment exposure and time since treatment also differ. [42, 43, 46, 98]

High satisfaction and low measured regret in selected treated cohorts matter. They show that many observed patients value treatment. They do not erase people who detransition, establish a universal one-percent rate, or provide lifetime outcomes for everyone treated in adolescence. Likewise, self-selected detransitioner surveys document real experiences and service gaps but cannot calculate prevalence. [12, 32, 42, 46, 98]

WHAT THE EVIDENCE ALLOWS US TO SAY

The rate is uncertain. The outcome can be serious. Follow-up and reversal pathways have often been inadequate. Responsible medicine must track and care for every outcome, including continuation, discontinuation, regret, and detransition. **[42-45, 78, 79, 98]**

12. Informed consent and adolescent development

Consent is a process, not a signature. It should include diagnostic uncertainty, reasonable alternatives, expected physical effects, evidence certainty for claimed psychosocial benefits, known and uncertain harms, fertility and sexual-function implications, monitoring, stopping, and what happens if goals change. [17, 24, 25, 48, 49]

Adolescents can understand information and express values, but they may have difficulty weighing distant fertility, sexual, and health consequences while in acute distress or under social pressure. The Dutch team argues that carefully selected patients in a staged multidisciplinary protocol can meaningfully participate in consent. Critical authors question whether current practice reliably reproduces those safeguards. Both perspectives should be presented. [33, 48-51]

The evidence does not justify claiming that no adolescent can understand anything about treatment. It also does not justify treating assent plus parental permission as automatically sufficient for permanent, uncertain, development-altering interventions.

PART III

Why Chloe calls gender-affirming care a scam

Chloe uses the word deliberately and defines it carefully.

DEFINITION

Chloe uses **scam** to describe an institutional treatment model sold through comforting branding, exaggerated certainty, fear-based consent, and euphemisms that hide the physical transaction. It is a moral and political judgment about the model and its public claims. It is not a claim that every clinician commits criminal fraud, knowingly lies, or lacks compassion.

Sales pitch	What families may hear	What a fully honest consent process must say
The brand	"Gender-affirming care" implies that affirmation is the care and that alternative approaches are denial.	Care should be judged by evidence, outcomes, honesty, and protection of the patient's future, not by a morally loaded label.
The body	The language emphasizes identity and authenticity.	The interventions suppress healthy puberty, impose non-native sex traits, or remove healthy tissue. The body bears the irreversible cost.
Reversibility	Blockers are often described as a neutral pause or fully reversible.	Puberty usually resumes after stopping, but the full bone, sexual, fertility-pathway, and neurodevelopmental consequences are not settled.
Suicide	Families can be told that transition is necessary to keep a child alive.	No reliable evidence establishes that blockers, hormones, or surgery prevent suicide death. Acute risk requires ordinary crisis care.
Evidence	Professional statements may describe treatment as safe, effective, or medically necessary.	Repeated reviews find key benefits supported by low or very-low certainty evidence and major long-term gaps.
Consensus	A list of organizations is offered as proof that the science is settled.	Guidelines often cite one another and combine evidence with values. International official reviews and policies have diverged.
Consent	A child's stated identity can be treated as sufficient evidence of a durable treatment goal.	No tool reliably predicts persistence, regret, or who will benefit. Adult consequences are imposed before adult maturity.
Aftercare	The pathway is presented as a coherent standard of care.	Detransition research documents fragmented follow-up, difficulty finding clinicians, and lack of structured reversal pathways.

By medical-industrial complex, this guide means a network of professional bodies, clinics, advocacy groups, researchers, lawyers, funders, insurers, pharmaceutical and surgical services, and public institutions that can reinforce one another's language and incentives. Institutional consensus can be sincere and still be wrong, circular, slow to correct, or insufficiently attentive to harmed patients. [6, 7, 24-28, 48-68, 83-85]

The strongest critique is structural: weak evidence was translated into confident public claims; euphemisms disguised irreversible mechanisms; dissent was often treated as hostility; and families were sometimes pressured through

catastrophic suicide predictions. Chloe's personal experience cannot establish how often that happened, but it proves that it happened and that the consequences can be permanent. [24, 48-52, 63-69, 88]

THE SHORTEST ACCURATE VERSION

The scam is not that distress is fake. The scam is telling children that their healthy bodies are the problem, selling medical alteration as affirmation, and presenting an uncertain pathway as settled, reversible, and life-saving.

13. Parents, clinicians, and the proper order of responsibility

Parents are not infallible. Neither are clinicians, professional associations, courts, schools, or government agencies. The question is who normally carries the primary duty to know and protect a particular child. American law has long treated fit parents as presumptively acting in their children's best interests and recognizes a fundamental liberty interest in care, custody, and control. That presumption is rebuttable and does not erase safeguards for abuse, neglect, or genuine medical emergencies. [100, 101]

Clinicians possess specialized knowledge. Parents possess longitudinal knowledge of the child: development, temperament, family history, trauma, school, friendships, beliefs, vulnerabilities, and patterns that may never appear in a clinic visit. Good medicine should join those forms of knowledge rather than using professional status to displace the parent.

A BALANCED RULE

Medical professionals advise. Fit parents decide within the law. Parents should listen carefully to qualified clinicians, seek second opinions, and remain open to evidence. Clinicians should explain uncertainty, respect parental authority, and never use unsupported suicide claims to coerce consent. **[88, 100, 101]**

This does not mean every parent must choose Chloe's policy view under current law. It means a system that treats parental caution as abuse, withholds material information, or pressures families through fear has reversed the proper relationship between expert advice and parental responsibility.

PART IV

Common claims and direct answers

These direct answers address common claims while keeping each conclusion within the limits of the evidence.

"The science proves these treatments work."

Some observational studies report short-term improvement, especially after hormones. Repeated systematic reviews nevertheless rate key causal conclusions low, very low, or otherwise uncertain because of selection, confounding, weak comparators, attrition, inconsistent outcomes, and limited long-term follow-up. The evidence does not justify a blanket promise of safety or durable net benefit for minors. [2, 3, 8-13, 29, 30, 89-103]

"Every major medical association agrees the care is safe and effective."

Several influential U.S. organizations support selected access. That is a policy fact, not proof of high-certainty efficacy. Official evidence reviews and policies in England, Finland, Sweden, Norway, New Zealand, and France have moved in more cautious directions, and the American Society of Plastic Surgeons now addresses delay of gender surgery under 19. [6, 7, 9, 17-28, 87, 99]

"Puberty blockers are fully reversible and just buy time."

Suppression ends when the drug is discontinued and endogenous puberty generally resumes. But bone accrual is affected, treatment timing cannot be replayed, and evidence is incomplete for long-term bone, sexual, fertility-pathway, and neuropsychological outcomes. "Fully reversible" is broader than the evidence supports. [2, 8-10, 34-36, 80, 89, 93-95]

"These are the same drugs safely used for precocious puberty."

The drug may be the same while the indication, age, duration, baseline population, treatment goal, and next step differ. Evidence from precocious puberty is relevant to drug safety. It does not prove independent mental-health benefit for gender dysphoria or the net outcome of a blocker-to-hormone pathway. [2, 8, 10, 80, 89]

"Gender-affirming care prevents suicide."

Current studies do not establish that blockers, hormones, or surgery prevent suicide death. Some observational studies show favorable associations with depression, suicidal thoughts, or self-harm composites. Those outcomes matter, but they cannot establish a life-saving causal effect. [29, 30, 37, 70, 90, 103]

"Without transition, children will die."

No responsible consent process should force a family to choose between an elective intervention and death. Acute risk requires suicide assessment, crisis planning, treatment of psychiatric illness, family safety measures, and emergency care when needed. The evidence does not support a guarantee that transition prevents death. [30, 37, 70, 88]

"Cass threw out 98 percent of the studies."

Quality appraisal is not the same as deleting evidence. The York reviews considered the literature while giving less reliable studies less evidentiary weight. The BMA's 2026 reanalysis found no incorrectly categorized high-quality studies or clear systematic bias and broadly supported the conclusion that certainty is low. It also criticized some Cass narrative wording as simplified or insufficiently substantiated. [1-9, 83-85]

"Randomized trials would be impossible and unethical."

Randomization may be difficult for some questions, but the reviews did not discard all nonrandomized evidence. The problem is the combined pattern of small selected samples, weak or absent comparators, confounding, missing data, inconsistent measures, and short follow-up. Better prospective comparative cohorts, registries, and linkage studies are feasible. [2, 3, 9-11, 89, 91]

"Low-certainty evidence is common in pediatrics."

True. An evidence grade alone does not dictate policy. Decision-makers must consider condition severity, alternatives, reversibility, developmental capacity, known and plausible harms, and the cost of error. The burden is reasonably higher for elective interventions that can permanently alter a minor's sexual development, fertility, or anatomy. [9, 13, 17, 24]

"Regret is only one percent."

Some surgical and treated cohorts report low measured regret, and that evidence matters. A single percentage cannot be transferred to all youth pathways. Definitions, follow-up duration, loss to follow-up, age, intervention, and willingness to return to the same clinic all affect the result. [12, 32, 42, 43, 46, 98]

"Detransition is vanishingly rare."

The prevalence after treatment begun in youth is not known with precision. Responsible practice requires long-term tracking, honest consent, and competent care for people who stop or reverse treatment, regardless of whether the eventual rate is high or low. [42-46, 78, 79, 98]

"Surgery does not happen to minors."

Administrative data show that gender-related surgeries have occurred in minors, mainly chest procedures. They are uncommon relative to the adolescent population. Exact totals remain uncertain because coding, indication, insurance coverage, and cash-pay care are imperfectly observed. [17, 40, 41, 64, 86]

"Social transition is harmless because it is reversible."

It does not directly alter the body, but it is a meaningful psychosocial intervention. It may relieve immediate distress and can also shape family, school, peer, and identity expectations. Evidence is too limited to establish long-term benefits, harms, or causal effects on persistence. [5, 31]

"Watchful waiting or exploratory therapy is conversion therapy."

Coercive therapy aimed at forcing a predetermined identity or sexual orientation is unethical. Open-ended therapy that treats distress, explores meaning, addresses co-occurring problems, and allows any eventual identity outcome is different. A cautious model should reject predetermined outcomes in both directions. [4, 15, 18, 77]

"Children know who they are."

Young people are authoritative about their current feelings and deserve to be heard. Identity, goals, sexuality, and body image can also develop during adolescence. Respecting a child's experience does not require pretending that clinicians can predict a lifelong outcome or that every requested intervention has a favorable risk-benefit ratio. [1, 31, 39, 92]

"The Dutch protocol proved the pathway works."

The Dutch cohort reported favorable outcomes in carefully selected patients completing a staged protocol. It is an important signal and model, not proof for all current referrals. It was small, had no untreated control, involved surgery in adulthood, and differs from broader contemporary populations and practices. [33, 49, 51]

"This is a private family decision. Politicians should stay out."

Clinical decisions should be individualized and protected from partisan theater. Governments also regulate drugs, consent, minors, professional standards, public funding, and medical liability. The real question is which safeguards are proportionate and whether restrictions should be professional, administrative, civil, or criminal. [9, 14-17, 24, 100, 101]

PART V

International policy and professional disagreement

Current through July 19, 2026. Policy is not evidence of efficacy, but divergence shows that the claim of a single settled global consensus is false.

Jurisdiction	Current direction	Important context
England	Puberty blockers are not routinely commissioned. A new service specification published April 1, 2026 makes holistic, multidisciplinary care central. The hormone commissioning policy page was updated March 11, 2026 and states that the policy was paused during consultation on a revised policy.	The consultation proposal was not final at the research cutoff, and Cass did not recommend a blanket statutory ban or the withdrawal of all care. [1, 14-16]
Finland	Psychosocial-first, highly centralized care, with endocrine treatment considered case by case under strict criteria and surgery outside the minor pathway.	The model permits selected endocrine treatment under strict criteria and is not an absolute ban on every intervention. [18]
Sweden	Weak negative recommendation at group level. Hormones and mastectomy are limited to exceptional cases, with hormonal care preferably in research.	The guidance is nonbinding and permits exceptional cases. [19, 20]
Norway	The official investigation board recommended investigational status and guideline revision, and regional medical directors supported a more cautious classification.	The national guideline had not yet been fully replaced, and no national statutory ban was in effect. [21]
New Zealand	Regulations adopted in 2025 restrict new blocker prescriptions for gender dysphoria while allowing specified continuation. The High Court ordered non-enforcement pending judicial review.	The regulations remained in force but were not being enforced while judicial review continued. [22, 23]
France	The French National Academy of Medicine urged careful assessment, psychological support, parental vigilance, and great caution with irreversible treatment.	The academy statement is influential professional guidance, not legislation. [99]
United States	The Endocrine Society, WPATH, and AAP continue to support selected access. ASPS has issued a 2026 statement on delaying gender surgery under 19. Federal and state policy remains contested.	There is no single U.S. professional or legal position. Current law must be checked state by state. [17, 24-28, 87]

WHAT POLICY DIVERGENCE SHOWS

It proves that responsible institutions have interpreted the same uncertain evidence differently. It does not prove that every restriction is correct or that every permissive policy is corrupt. The policy case must still be made from evidence, ethics, parental responsibility, and protection of the child's future.

PART VI

The strongest evidence offered in support of transition

The strongest supportive evidence should be considered directly. These studies report important benefit signals, but each has limits when applied to lifelong risk and benefit for minors.

Source	Finding	Why it matters	Key limitation
Chen et al. 2023	315 participants aged 12 to 20 followed for two years after hormones; appearance congruence and several psychosocial measures improved.	Prospective, multicenter, clinically relevant patient-reported outcomes.	No untreated comparator; selected supportive clinics; confounding, attrition, and short follow-up relative to a lifetime. [29]
Tordoff et al. 2022	104 patients; blocker or hormone receipt associated with lower odds of depression and a suicidality/self-harm composite over 12 months.	Prospective design, adjusted models, and large observed associations.	Nonrandomized; combined treatments; residual confounding; missing medication data; composite outcome; no suicide deaths. [30]
de Vries et al. 2014	Favorable young-adult psychological outcomes after a staged Dutch protocol.	Longitudinal pathway with careful selection and follow-up.	Small completer cohort; no untreated control; surgery in adulthood; limited generalizability to current referrals. [33]
Olson et al. 2022	Early social-transition cohort showed high identity stability after about five years.	Prospective cohort with repeated follow-up.	Selected families; no random assignment; cannot establish that social transition caused persistence. [31]
Olson et al. 2024	High satisfaction and uncommon measured regret among observed early transitioners receiving medical care.	Direct patient-reported outcomes and several years of follow-up.	Selection, response, measurement, and still-limited adulthood horizon. [32]
Baker 2021; van Leerdam 2023; Doyle 2023	Systematic reviews of mixed-age hormone literature report favorable associations or consistent improvement in some psychosocial outcomes.	Broad source collection and recognition of patient-reported benefit signals.	Much of the literature is adult, uncontrolled, confounded, or not designed to answer youth-specific lifelong risk-benefit questions. [90, 102, 103]
Endocrine Society, WPATH, AAP	Support individualized access under multidisciplinary care.	Clinical expertise, patient values, and harm-reduction reasoning.	Guidelines combine evidence with values; York found methodological weaknesses across much guidance. [6, 7, 25, 27, 28]

The fair synthesis is that supportive observational evidence contains recurring signals of improved appearance congruence, depressive symptoms, distress, and some short-term psychosocial outcomes, particularly after hormones. The dispute concerns causal confidence, durability, patient selection, long-term physical and sexual outcomes, and whether those signals justify development-altering and irreversible intervention before adulthood. [3, 9, 11, 13, 29, 30, 90, 102, 103]

Chloe's position remains unchanged: short-term benefit signals do not justify altering a minor's healthy sexual development. Children are not mature enough to carry lifelong consequences, long-term net benefit remains uncertain, non-destructive support is available, and every child retains a right to an open future.

PART VII

Support for parents, families, and detransitioners

The immediate goal is safety, relationship, competent care, and preservation of future options. A person does not need to agree with Chloe's politics to deserve help.

A PARENT SCRIPT

"I love you. I believe that what you feel is real. We do not have to decide everything today. My job is to keep you safe, understand everything that may be contributing, and avoid rushing decisions we cannot fully undo. I will stay with you while we find competent help."

14. The first 24 hours

- **Stay calm and preserve the relationship.** Do not ridicule, threaten, expel, publicly expose, or force a declaration.
- **Check immediate safety.** Ask directly about suicidal thoughts, plan, intent, timing, and access to lethal means. A direct question does not plant the idea.
- **Reduce the temperature.** Do not promise transition and do not issue an ultimatum. Say that love and help are not conditional on adopting a label.
- **Stabilize ordinary needs.** Sleep, food, school attendance, medication adherence, substance use, bullying, isolation, and acute psychiatric symptoms come first.
- **Pause irreversible decisions.** A short delay for records, assessment, and a second opinion is not abandonment. It is responsible care.
- **Write down what changed.** Record when distress began, what language appeared, relevant events, online influences, health symptoms, and any safety concerns.

15. The first 30 days

1. Arrange a comprehensive assessment that can consider depression, anxiety, OCD, trauma, autism or ADHD, eating disorders, body image, sexuality, family dynamics, online context, and medical causes without assuming a predetermined identity outcome.
2. Request complete records and build a timeline: symptoms, therapy, diagnoses, medications, doses, labs, imaging, consent forms, referrals, emergency visits, and procedures. U.S. patients generally have HIPAA access rights, with exceptions and state-law details. [69]
3. Ask for evidence in absolute terms: What outcome is being targeted? How many comparable patients improve? How certain is the estimate? What are the known and unknown harms? What happens if we wait?
4. Seek a second opinion before any irreversible step. Verify licensing, discipline history, adolescent experience, telehealth jurisdiction, confidentiality policy, and willingness to coordinate care.
5. Keep ordinary life large: family meals, school, hobbies, movement, friendships, faith or community when welcome, service, pets, and time offline. Do not make gender the only subject in the child's life.
6. Set a review date rather than an ultimatum. Track distress, function, safety, and goals over time. Update the plan without shaming the young person.
7. Protect privacy. Do not turn a child's uncertainty into a public campaign, schoolwide announcement, or permanent digital record unless truly necessary.
8. Create an emergency plan with crisis contacts, responsible adults, medication information, and clear steps for imminent danger.

16. Questions for a clinician

Topic	Questions
Assessment	What diagnoses and alternative explanations were considered? How were trauma, autism, OCD, eating problems, depression, sexuality, body image, family stress, school, and online context assessed?
Goal	What specific symptom or function is the intervention expected to improve: dysphoria, appearance, depression, anxiety, school function, or suicide risk?
Evidence	What is the best systematic review for a patient like this one? What is the certainty? Are reported benefits causal or associative?
Alternatives	What psychosocial, family, school, psychiatric, and medical options are available? What is known about delayed intervention?
Irreversibility	Which effects are permanent, partly reversible, or unknown? What may happen to fertility, sexual function, voice, breast tissue, bone, growth, or future surgical options?
Pathway	How many patients who start blockers progress to hormones in this service? How is the independent benefit of each step assessed?
Monitoring	Which labs, imaging, symptoms, and mental-health outcomes will be tracked? Who is responsible if the patient moves or the clinic closes?
Changing goals	How will the team respond to ambivalence, stopping, regret, or detransition? Is there a written aftercare pathway?
Data	Will outcomes be entered in a registry? How are people lost to follow-up counted? Can the family receive the full consent form in advance?
Conflicts	What financial, institutional, research, advocacy, litigation, or referral relationships are relevant to this recommendation?

17. Vetting a therapist or support group

- Confirm an active professional license through the relevant regulator and check disciplinary history. Referral lists are not guarantees. [72, 77]
- Ask whether the approach is open-ended and whether any identity outcome is predetermined. Avoid promises to confirm, cure, reverse, or make a child desist.
- Ask about experience with adolescent development, autism, OCD, trauma, eating disorders, family therapy, suicide assessment, and detransition care.
- Confirm privacy, data retention, recording, mandated reporting, minor consent, parent involvement, and telehealth-jurisdiction rules.
- For peer groups, ask who moderates, whether political or medical advice is given, what happens during a crisis, and whether commercial or advocacy referrals are disclosed.
- Be cautious when a provider treats questions about evidence or alternatives as proof of hostility. Competent care should tolerate respectful inquiry.

18. Schools and everyday life

- **Request a written plan.** Clarify names in records, parent notification, counseling, privacy, bullying response, restrooms, sports, overnight trips, and who can make changes.

- **Do not let the school become a secret clinical system.** Ask what information may be withheld from parents and what state law or district policy is being relied upon.
- **Protect the child from bullying without requiring false statements about sex.** Safety and courtesy do not require agreement on metaphysical claims.
- **Keep accommodations narrow and reviewable.** Solve concrete problems such as harassment, changing spaces, or anxiety without creating a permanent identity bureaucracy.
- **Document material conversations.** Keep emails, policies, meeting notes, and names. Seek jurisdiction-specific legal advice when rights or safety are disputed.

19. For detransitioners and people reconsidering treatment

9. You do not need to prove a new identity or adopt a political label to ask for help. It is acceptable to be certain, uncertain, ambivalent, or to change goals more than once.
10. Do not abruptly stop hormones or other prescribed medication without medical guidance. Ask for a discontinuation or maintenance plan based on treatment history and organs present. [81, 82]
11. Request complete records: medication and dose history, labs, imaging, consent forms, operative and pathology reports, complications, photographs when relevant, and communications. [69]
12. Build care around needs, not ideology. This may include primary care, endocrinology, gynecology or urology, reproductive endocrinology, reconstructive surgery, pelvic-floor therapy, dermatology, ENT, speech-language pathology, pain care, and mental-health care.
13. Continue preventive screening based on organs present, treatment history, age, and individual risk. Ask the clinician to document a clear plan.
14. Discuss fertility goals early. Options and probability of recovery vary with pubertal stage, duration, drugs, surgery, age, and individual biology. Avoid promises in either direction. [96, 97]
15. For pain, scarring, sensation changes, urinary or pelvic symptoms, chest concerns, or reconstruction questions, seek a clinician with relevant expertise. Urgent symptoms need prompt care.
16. Consider peer support for isolation and practical knowledge, while treating it as peer support rather than individualized medical advice. [62, 74-76, 98]
17. If you suspect negligence, preserve records and dates. State medical boards offer complaint routes, and bar-sponsored directories can help locate legal advice. Deadlines vary. [72, 73]

20. Support and crisis directory

Resource	What it is	Best use	Important note
988 Suicide and Crisis Lifeline	U.S. crisis support by call, text, or chat	Immediate emotional or suicide crisis	Not long-term therapy. Call 911 for immediate danger. [70]
SAMHSA FindTreatment.gov	U.S. mental-health and substance-use locator	Finding local licensed services	Verify fit, licensing, and treatment approach directly. [71]
Beyond Trans	Peer-led and therapist-facilitated groups	Community and reduced isolation	Affiliated with Genspect. Groups are peer support, not psychotherapy, diagnosis, or medical treatment. [62]
Detrans Support	Canadian research-informed information project	Education and service navigation	Not emergency or individualized medical care. [74]
Post Trans	Detransitioner-led multilingual resources and stories	Lived experience and practical orientation	Personal accounts do not establish prevalence or clinical efficacy. [75]
Detrans Foundation	Small UK psychologist-led service	Potential psychological support	Licensing, availability, jurisdiction, and cost should be verified directly. [76]
Therapy First	Professional association and referral request	Finding therapists favoring open-ended care	The association does not supervise or guarantee listed providers. Verify each provider independently. [77]
FSMB directory	Links to U.S. state medical boards	Licensing, discipline checks, complaints	A complaint is not urgent care or legal advice. [72]

Resource	What it is	Best use	Important note
ABA lawyer finders	Bar-sponsored directories and referrals	Locating jurisdiction-specific legal advice	A listing is not a guarantee; ask about experience, fees, and deadlines. [73]

ABOUT THIS REVIEW

Sources and disclosures

This guide distinguishes systematic reviews, cohort studies, guidelines, policy documents, commentary, advocacy, journalism, and personal testimony. Each source is used according to what its design can establish.

How sources are handled

- Chloe Cole is affiliated with Do No Harm as a patient advocate. That affiliation is relevant when this guide cites Do No Harm research or data. [63, 64, 88]
- The Manhattan Institute is a conservative public-policy think tank. Genspect is an advocacy network favoring nonmedicalized approaches. [58, 61]
- The 2025 McMaster reviews were funded by SEGM, which helped select the questions. The authors later rejected using low-certainty findings as proof of no benefit and stated that they would not accept further SEGM funding. [10-13]
- The 2025 HHS report is a government-commissioned, post-publication peer-reviewed synthesis written from a policy context favoring restriction. Its evidence claims are considered alongside York, BMA, NICE, McMaster, SBU, and other independent reviews. [2, 3, 8-11, 20, 24, 89-91]
- Relevant funding, conflicts, and advocacy positions are identified for both supportive and skeptical sources.
- Personal testimony can establish that an experience occurred and matters morally; it cannot establish frequency or causation. [88]

REFERENCES

References

References are numbered in order of citation. DOI, official-government, professional-society, and stable publisher links were reviewed during preparation.

1. Cass, H. Independent Review of Gender Identity Services for Children and Young People: Final Report. NHS England / UK National Archives (2024). View source.
2. Taylor, J., et al. Interventions to suppress puberty in adolescents experiencing gender dysphoria or incongruence: a systematic review. Archives of Disease in Childhood (2024). doi:10.1136/archdischild-2023-326669.
3. Taylor, J., et al. Masculinising and feminising hormone interventions for adolescents experiencing gender dysphoria or incongruence: a systematic review. Archives of Disease in Childhood (2024). doi:10.1136/archdischild-2023-326670.
4. Heathcote, C., et al. Psychosocial support interventions for children and adolescents experiencing gender dysphoria or incongruence: a systematic review. Archives of Disease in Childhood (2024).
5. Hall, R., et al. Impact of social transition in relation to gender for children and adolescents: a systematic review. Archives of Disease in Childhood (2024).
6. Taylor, J., et al. Clinical guidelines for children and adolescents experiencing gender dysphoria or incongruence: systematic review of guideline quality, part 1. Archives of Disease in Childhood (2024).
7. Taylor, J., et al. Clinical guidelines for children and adolescents experiencing gender dysphoria or incongruence: synthesis of recommendations, part 2. Archives of Disease in Childhood (2024).
8. National Institute for Health and Care Excellence Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria. Commissioned evidence review for NHS England (2020).
9. British Medical Association Cass Review: Evidence, Interpretation, and Implementation. BMA (2026). View source.
10. Miroshnychenko, A., et al. Puberty suppression in adolescents experiencing gender dysphoria or incongruence: a systematic review of comparative and before-after studies. Archives of Disease in Childhood (2025). doi:10.1136/archdischild-2024-327909.
11. Miroshnychenko, A., et al. Gender affirming hormone therapy for individuals with gender dysphoria aged under 26: a systematic review and meta-analysis. Archives of Disease in Childhood (2025). doi:10.1136/archdischild-2024-327921.
12. Miroshnychenko, A., et al. Mastectomy for individuals with gender dysphoria aged under 26: a systematic review and meta-analysis. Plastic and Reconstructive Surgery (2025). doi:10.1097/PRS.0000000000011734.
13. McMaster University Health Evidence and Impact Systematic reviews related to gender-affirming care. McMaster University (2025).
14. NHS England Clinical policy: puberty suppressing hormones. NHS England (2024).
15. NHS England Service specification: NHS Children and Young People's Gender Service. NHS England (2026). View source.
16. NHS England Consultation: prescribing masculinising and feminising hormones for children and adolescents. NHS England (2026). View source.
17. American Society of Plastic Surgeons Position Statement on Gender Surgery for Children and Adolescents. ASPS (2026). View source.
18. Council for Choices in Health Care in Finland Medical treatment methods for dysphoria associated with variations in gender identity in minors: summary. COHERE Finland (2020, technical update 2024).
19. Socialstyrelsen Care of children and adolescents with gender dysphoria: summary of national guidelines. Swedish National Board of Health and Welfare (2022).
20. Swedish Agency for Health Technology Assessment Hormone treatment of children and adolescents with gender dysphoria. SBU Report 342 (2022).
21. Norwegian Healthcare Investigation Board Patient safety for children and young people with gender incongruence. Ukom (2023).
22. New Zealand Ministry of Health Impact of puberty blockers in gender-dysphoric adolescents: an evidence brief. Manatu Hauora (2024).
23. New Zealand Ministry of Health. Puberty blockers. Ministry of Health NZ (updated 2026). View source.
24. U.S. Department of Health and Human Services Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices. Office of Population Affairs (2025, revised November 19). View source.
25. Hembree, W. C., et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society clinical practice guideline. Journal of Clinical Endocrinology and Metabolism (2017). doi:10.1210/jc.2017-01658.
26. Endocrine Society Statement in Support of Gender-Affirming Care. Endocrine Society (2024).
27. Coleman, E., et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. International Journal of Transgender Health (2022). doi:10.1080/26895269.2022.2100644.

28. Rafferty, J., et al. Ensuring comprehensive care and support for transgender and gender-diverse children and adolescents. Pediatrics / American Academy of Pediatrics (2018, reaffirmed 2023).
29. Chen, D., et al. Psychosocial functioning in transgender youth after 2 years of hormones. New England Journal of Medicine (2023). doi:10.1056/NEJMoa2206297.
30. Tordoff, D. M., et al. Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care. JAMA Network Open (2022). doi:10.1001/jamanetworkopen.2022.0978.
31. Olson, K. R., et al. Gender identity 5 years after social transition. Pediatrics (2022). doi:10.1542/peds.2021-056082.
32. Olson, K. R., et al. Satisfaction and regret following gender-affirming medical care in early socially transitioned youth. JAMA Pediatrics (2024).
33. de Vries, A. L. C., et al. Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics (2014).
34. Vlot, M. C., et al. Bone mineral density in transgender adolescents treated with puberty suppression and subsequent gender-affirming hormones. JAMA Pediatrics (2023).
35. Ciancia, S., et al. Impact of gender-affirming treatment on bone health in transgender and gender diverse youth. Endocrine Connections (2022).
36. Baxendale, S. The impact of suppressing puberty on neuropsychological function: a review. Acta Paediatrica (2024). doi:10.1111/apa.17150.
37. Ruuska, S. M., et al. All-cause and suicide mortalities among adolescents and young adults referred to gender identity services in Finland. BMJ Mental Health (2024). doi:10.1136/bmjment-2023-300940.
38. Kallitsounaki, A., and Williams, D. M. Autism spectrum disorder and gender dysphoria/incongruence: a systematic review and meta-analysis. Journal of Autism and Developmental Disorders (2023). doi:10.1007/s10803-022-05517-y.
39. Steensma, T. D., et al. Factors associated with desistence and persistence of childhood gender dysphoria. Journal of the American Academy of Child and Adolescent Psychiatry (2013).
40. Hughes, L. D., et al. Gender-affirming medications among transgender adolescents in the US, 2018-2022. JAMA Pediatrics (2025). doi:10.1001/jamapediatrics.2024.6081.
41. Dai, D., et al. Prevalence of gender-affirming surgical procedures among minors and adults in the US. JAMA Network Open (2024). doi:10.1001/jamanetworkopen.2024.18814.
42. MacKinnon, K. R., et al. Health care experiences of patients discontinuing or reversing prior gender-affirming treatments. JAMA Network Open (2022). doi:10.1001/jamanetworkopen.2022.24717.
43. Jorgensen, S. C. J. Transition regret and detransition: meanings and uncertainties. Archives of Sexual Behavior (2023).
44. Charlton, B. M., et al. Clinical considerations for working with patients who stop or reverse gender-affirming medical or surgical interventions. LGBT Health (2024).
45. Pullen Sansfacon, A., et al. A nuanced look into youth journeys of gender transition and detransition. Infant and Child Development (2023).
46. Littman, L. Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned. Archives of Sexual Behavior (2021). doi:10.1007/s10508-021-02163-w.
47. Littman, L. Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. PLOS ONE (2018, corrected 2019).
48. Levine, S. B., Abbruzzese, E., and Mason, J. W. Reconsidering informed consent for trans-identified children, adolescents, and young adults. Journal of Sex and Marital Therapy (2022). doi:10.1080/0092623X.2022.2046221.
49. de Vries, A. L. C., et al. Response to reconsidering informed consent. Journal of Sex and Marital Therapy (2022).
50. Abbruzzese, E., Levine, S. B., and Mason, J. W. The myth of reliable research in pediatric gender medicine. Journal of Sex and Marital Therapy (2023). doi:10.1080/0092623X.2022.2150346.
51. Biggs, M. The Dutch protocol for juvenile transsexuals: origins and evidence. Journal of Sex and Marital Therapy (2023). doi:10.1080/0092623X.2022.2121238.
52. Jorgensen, S. C. J., et al. Puberty blockers for gender dysphoric youth: a lack of sound science. Journal of Clinical Endocrinology and Metabolism (2024).
53. Wright, C. M. Why there are exactly two sexes. Archives of Sexual Behavior (2025).
54. Wright, C. M. Understanding the sex binary. Reality's Last Stand (2024).
55. Buttons, C. Gender Medicine Monthly. Buttons (2023-present).
56. Buttons, C. How autistic traits can be mistaken for gender dysphoria. Buttons (2023).
57. Buttons, C., Wright, C. M., and Stagg, S. Transgender brain studies are fatally flawed. City Journal (2025).
58. Sapir, L. 'Trust the Experts' Is Not Enough. Manhattan Institute (2022).
59. Sapir, L. A Consensus No Longer. City Journal (2024).
60. Sapir, L. A middle ground in pediatric gender medicine?. City Journal (2025).
61. Genspect Guidance and clinical support resources. Genspect (current).
62. Beyond Trans Support groups and resources. Beyond Trans / Genspect (current).
63. Do No Harm Unproven and Unsafe: The Evidence Gap in So-Called Gender-Affirming Care. Do No Harm (2025).

64. Do No Harm Stop the Harm database methodology. Do No Harm (2024).
65. Lindsay, J. Queer theory. New Discourses (2020).
66. Wokal Distance Gender ideology destroyed institutional trust. Wokal Distance (2025).
67. Barnes, H. Time to Think: The Inside Story of the Collapse of the Tavistock's Gender Service for Children. Swift Press (2023).
68. Block, J. Gender dysphoria in young people is rising, and so is professional disagreement. BMJ (2023).
69. U.S. Department of Health and Human Services Your medical records. HHS Office for Civil Rights (updated 2025).
70. 988 Suicide and Crisis Lifeline Get help. 988 Lifeline (current). View source.
71. Substance Abuse and Mental Health Services Administration FindTreatment.gov. SAMHSA (current). View source.
72. Federation of State Medical Boards Contact a state medical board. FSMB (current). View source.
73. American Bar Association Bar directories and lawyer finders. ABA (current). View source.
74. Detrans Support Research-informed information for detransitioners. detransinfo.com (current). View source.
75. Post Trans Detrans resources. Post Trans (current). View source.
76. Detrans Foundation Psychological support for detransitioners. Detrans Foundation (current). View source.
77. Therapy First Provider referral request. Therapy First (current). View source.
78. Royal College of General Practitioners Transgender care. RCGP (current).
79. NHS England Implementing advice from the Cass Review. NHS England (current).
80. Mayo Clinic Puberty blockers for transgender and gender-diverse youth. Mayo Clinic (updated 2026). View source.
81. Mayo Clinic Masculinizing hormone therapy. Mayo Clinic (current). View source.
82. UCSF Transgender Care Bone health and osteoporosis. University of California, San Francisco (current). View source.
83. Yale Integrity Project An evidence-based critique of the Cass Review. Yale Law School (2024).
84. Noone, C., et al. Critically appraising the Cass report. BMC Medical Research Methodology (2025).
85. Moore, E., et al. The Cass Review does not guide care for trans young people. International Journal of Transgender Health (2025).
86. Wright, J. D., et al. National estimates of gender-affirming surgery in the United States. JAMA Network Open (2023).
87. American Academy of Pediatrics AAP reaffirms gender-affirming care policy, authorizes systematic review. AAP News (2023). View source.
88. Cole, C. Statement to the U.S. Senate Committee on Health, Education, Labor, and Pensions. U.S. Senate HELP Committee (2026). View source.
89. Ludvigsson, J. F., et al. A systematic review of hormone treatment for children with gender dysphoria and recommendations for research. Acta Paediatrica (2023). doi:10.1111/apa.16791.
90. Baker, K. E., et al. Hormone therapy, mental health, and quality of life among transgender people: a systematic review. Journal of the Endocrine Society (2021). doi:10.1210/jendso/bvab011.
91. Thompson, L., et al. A PRISMA systematic review of adolescent gender dysphoria literature: 3) treatment. PLOS Global Public Health (2023). doi:10.1371/journal.pgph.0001478.
92. Stynes, H., et al. Gender identity development in children and young people: a systematic review of longitudinal studies. Clinical Child Psychology and Psychiatry (2021). doi:10.1177/13591045211002620.
93. Carmichael, P., et al. 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 (2021). doi:10.1371/journal.pone.0243894.
94. Schagen, S. E. E., et al. Bone development in transgender adolescents treated with GnRH analogues and subsequent gender-affirming hormones. Journal of Clinical Endocrinology and Metabolism (2020). doi:10.1210/clinem/dgaa604.
95. van der Loos, M. A. T. C., et al. Bone mineral density in transgender adolescents treated with puberty suppression and subsequent gender-affirming hormones. JAMA Pediatrics (2023). doi:10.1001/jamapediatrics.2023.4588.
96. Chen, D., et al. Fertility preservation for transgender adolescents. Journal of Adolescent Health (2017). doi:10.1016/j.jadohealth.2017.01.022.
97. Nahata, L., et al. Low fertility preservation utilization among transgender youth. Journal of Adolescent Health (2017). doi:10.1016/j.jadohealth.2016.12.012.
98. Vandenbussche, E. Detransition-related needs and support: a cross-sectional online survey. Journal of Homosexuality (2022). doi:10.1080/00918369.2021.1919479.
99. Academie nationale de medecine. Medicine and gender transidentity in children and adolescents. French National Academy of Medicine (2022). View source.
100. Parham v. J.R., 442 U.S. 584 (1979). U.S. Supreme Court. View source.
101. Troxel v. Granville, 530 U.S. 57 (2000). U.S. Supreme Court. View source.
102. van Leerdam, T. R., Zajac, J. D., and Cheung, A. S. The effect of gender-affirming hormones on gender dysphoria, quality of life, and psychological functioning in transgender individuals: a systematic review. Transgender Health (2023). doi:10.1089/trgh.2020.0094.
103. Doyle, D. M., Lewis, T. O. G., and Barreto, M. A systematic review of psychosocial functioning changes after gender-affirming hormone therapy among transgender people. Nature Human Behaviour (2023). doi:10.1038/s41562-023-01605-w.

CLOSING

Truth, healing, courage

FOR THE CHILD WHO IS HURTING

You are not a mistake. Your body is not your enemy. You do not have to solve your entire life today. You deserve adults who will protect you from cruelty, listen without panic, tell you the truth, and help you build a life larger than your distress.

CHLOE COLE

Truth. Healing. Courage. Protection for children.